HEALTH HISTORY

CONFIDENTIAL

Patient Name:______________________________ Today's Date:_____________

Age:________ Birthdate:________ Date of last physical examination___________

What is your reason for visit?____

____

SYMPTOMS check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-flashes
- ☐ Vision-halos

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period:______________
Date of last Pap Smear: ______________
Have you had a mammogram:______________
Are you pregnant?______________
Number of children?______________

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

CONDITIONS

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

MEDICATION List medications you are currently taking.

Pharmacy Name Phone

ALLERGIES To medications or substances

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age of Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brother(s)					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sister(s)					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization & Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS

Check (✓) which substances you use & describe how much you use.

	Substance
	Caffeine
	Tobacco
	Street Drugs
	Other

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. ______________________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS

Check (✓) if, your blood relatives had any of the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

To the best of my knowledge, the above information is completed and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative — Date

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Reviewed By: — Date

CHART # ____________ **PROVIDER:** ____________

PATIENT INFORMATION

PATIENT NAME: ________________________________
LAST FIRST MIDDLE

ADDRESS: ________________________________

CITY: ______________ STATE: ________ ZIP CODE: ________

HOME PHONE # ______________ WORK PHONE # ______________

DATE OF BIRTH: ______________ SOCIAL SECURITY # ______________

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OTHER________

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (CIRCLE ONE)

SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN: ______________ REFERRED BY: ______________

PATIENT'S EMPLOYER INFORMATION:

COMPANY: ______________ CITY: ______________

SUPERVISOR: ______________ PHONE #: ______________

ACCIDENT INFORMATION: DATE OR ACCIDENT: ________ WORK RELATED? ________ AUTO ________ OTHER ________

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: ________________________________
LAST FIRST MIDDLE

ADDRESS: ________________________________

DATE OF BIRTH: ______________ SEX: (CIRCLE ONE) FEMALE MALE

HOME PHONE # ______________ WORK PHONE # ______________

SOCIAL SECURITY # ______________

RESP. EMPLOYER INFORMATION:

COMPANY: ______________ CITY: ______________

SUPERVISOR: ______________ PHONE #: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ________________________________

ADDRESS: ______________ PHONE #: ______________

CONTRACT (ID) NUMBER: ______________ SUBSCRIBER'S NAME: ______________

PATIENT RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE)

SELF SPOUSE CHILD OTHER

GROUP NAME: ______________ GROUP #: ______________

COPAYMENT AMOUNT $ ______________ INSURED'S DATE OF BIRTH: ______________

SECONDARY INSURANCE COMPANY: ________________________________

ADDRESS: ______________ PHONE #: ______________

CONTRACT (ID) NUMBER: ______________ SUBSCRIBER'S NAME: ______________

PATIENT RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE)

SELF SPOUSE CHILD OTHER

GROUP NAME: ______________ GROUP #: ______________

COPAYMENT AMOUNT $ ______________ INSURED'S DATE OF BIRTH: ______________

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangement has been specifically made. All accounts over 60 days will be charged an interest rate of 1 ½ percent per month per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including reasonable attorney fees.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records not release any of the medical information obtained by this authorization to other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED:____ DATE:______________________

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME:____

PHONE NUMBER:__________________________RELATIONSHIP:___________________

ADDRESS:____

____