Welcome to Our Practice

As a new patient, please fill out the information found below to the best of your ability.

Patient # _____ Physician _____ Date _____

Patient name _____ Chief complaint _____

History of Present Illness:

Location _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 [5 being the most severe])

Duration _____
(How long have you had this pain/problem, or when did it start?)

Timing _____
(Does this pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated Signs/ Symptoms _____
(What other associated problems have you been having?)

Modifying Factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Patient Medical History:

Measles	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes	Blood or Plasma Transfusions	☐ No	☐ Yes	Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Anemia	☐ No	☐ Yes	Back Trouble	☐ No	☐ Yes	Mitral Valve Prolapse	☐ No	☐ Yes
Chickenpox	☐ No	☐ Yes	Bladder Infections	☐ No	☐ Yes	High or Low Blood Pressure	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Whooping Cough	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Scarlet Fever	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes
Diphtheria	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Hives or Eczema	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Smallpox	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Infectious Mono	☐ No	☐ Yes	Bleeding Tendency	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Polio	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes	Any Other Disease (please list) _____	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Date of last chest x-ray: _____					
Arthritis	☐ No	☐ Yes	Hernia	☐ No	☐ Yes						

Previous Hospitalizations/Surgeries/Serious Illnesses When Hospital, City, State/Prov.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications (include nonprescription):

_____

Have you ever taken Fen-Phen/Redux? ☐ No ☐ Yes

Patient Social History:

Marital status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Use of alcohol:	☐ Never	☐ Rarely	☐ Moderate	☐ Daily	
Use of tobacco:	☐ Never	☐ Previously, but quit: _____		☐ Current packs/day _____	
Use of drugs:	☐ Never	☐ Type/frequency: _____			
Excessive exposure at home or work to:	☐ Fumes	☐ Dust	☐ Solvents	☐ Airborne particles	☐ Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Over Please

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

Good general health lately	☐ No	☐ Yes
Recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes

EYES

Eye disease or injury	☐ No	☐ Yes
Wear glasses/contact lenses	☐ No	☐ Yes
Blurred or double vision	☐ No	☐ Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	☐ No	☐ Yes
Earaches or drainage	☐ No	☐ Yes
Chronic sinus problems or rhinitis	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Bad breath or bad taste	☐ No	☐ Yes
Sore throat or voice change	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes

CARDIOVASCULAR

Heart trouble	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes
Palpitation	☐ No	☐ Yes
Shortness of breath walking or lying flat	☐ No	☐ Yes
Swelling of feet, ankles or hands	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent coughs	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetite	☐ No	☐ Yes
Change in bowel movements	☐ No	☐ Yes
Nausea or vomiting	☐ No	☐ Yes
Frequent diarrhea	☐ No	☐ Yes
Painful bowel movements or constipation	☐ No	☐ Yes
Rectal bleeding or blood in stool	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes

GENITOURINARY

Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Change in force of strain when urinating	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Kidney stones	☐ No	☐ Yes
Sexual difficulty	☐ No	☐ Yes
Male - testicle pain	☐ No	☐ Yes
Female - pain with periods	☐ No	☐ Yes
Female - irregular periods	☐ No	☐ Yes
Female - vaginal discharge	☐ No	☐ Yes

Female - # of pregnancies: _____

Female - # of miscarriages: _____

Female - date of last pap smear: _____

MUSCULOSKELETAL

Joint pain	☐ No	☐ Yes
Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles or joints	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Cold extremities	☐ No	☐ Yes
Difficulty in walking	☐ No	☐ Yes

INTEGUMENTARY (skin, breast)

Rash or itching	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Change in hair or nails	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Breast discharge	☐ No	☐ Yes

NEUROLOGICAL

Frequent or recurring headaches	☐ No	☐ Yes
Light headed or dizzy	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Numbness or tingling sensations	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Head injury	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Nervousness	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

ENDOCRINE

Glandular or hormone problem	☐ No	☐ Yes
Excessive thirst or urination	☐ No	☐ Yes
Heat or cold intolerance	☐ No	☐ Yes
Skin becoming dryer	☐ No	☐ Yes
Change in hat or glove size	☐ No	☐ Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	☐ No	☐ Yes
Bleeding or bruising tendency	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes
Past transfusion	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	☐ No	☐ Yes
Morphine, Demerol, or other narcotics	☐ No	☐ Yes
Novocain or other anesthetics	☐ No	☐ Yes
Aspirin or other pain remedies	☐ No	☐ Yes
Tetanus antitoxin or other serums	☐ No	☐ Yes
Iodine, merthiolate or other antiseptics	☐ No	☐ Yes

Other drugs/medications? _____

Known food allergies: _____

Environmental allergies: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Review: _____

Signature of Doctor Date

Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient name _____ (FIRST / MI / LAST) Patient # _____

SS#/SIN _____ ☐ Male ☐ Female Birthdate _____ Home phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell phone _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient or parent/guardian's employer _____ Work phone _____

Business address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or parent/guardian's name _____ Employer _____ Work phone _____

If patient is a student, name of school/college _____ City _____ State/Prov. _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Email _____ Cell phone _____

Driver's license # _____ Birthdate _____ Financial Institution _____

Employer _____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Insurance co. address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance company _____ Group # _____ Union or local # _____

Insurance co. address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____

Signature of patient (or parent/guardian if minor) Date

Personal Information and HIPAA

Personal Information (Please Print)

Full Name: _____ DOB: _____SSN#_____

Address: _____

Primary Phone: (____) _____ Secondary Phone: (____) _____ Sex: Male Female

Emergency Contact and HIPPA Information (Please Print)

Emergency Contact Name: _____Relationship: _____

Primary Phone: (_____) _____ Home Cell Work

Secondary Phone: (_____) _____ Home Cell Work

May we leave messages on your answering machine/voicemail? ☐ **Yes** ☐ **No**

Please provide name(s) and contact information of the individuals that we may contact or speak to in regard to your medical information (this includes appointments, lab results, billing, etc.)

Name: _____ Relationship:_____ Phone: (_____)_____

Name: _____ Relationship:_____ Phone: (_____)_____

Patient Signature: _____Today's date _____