



WELCOME TO OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY, WE WILL NEED THE FOLLOWING INFORMATION FILLED OUT COMPLETELY AND UPDATED AS NECESSARY.

<u>PATIENT INFORMATION</u>	<p>LAST NAME: _____ FIRST NAME: _____ MI: _____</p> <p>SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH: ____/____/____ AGE: ____</p> <p>HOME PHONE: _____ CELL PHONE: _____</p> <p>ADDRESS: _____ CITY/STATE/ZIP: _____</p> <p>DO YOU CURRENTLY LIVE IN A NURSING HOME OR ASSISTED LIVING FACILITY? _____</p> <p>IF YES, WHICH ONE? _____</p> <p>ARE YOU CURRENTLY ENROLLED IN HOSPICE CARE? _____</p> <p>IF YES, EFFECTIVE DATE AND NAME OF HOSPICE? _____</p> <p>DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)? YES _____ NO _____</p> <p>IF YES, PLEASE PROVIDE A COPY.</p>
<u>EMERGENCY CONTACT</u>	<p style="text-align: center;">PLEASE MAKE SURE YOUR EMERGENCY CONTACT IS ON YOUR HIPAA FORM.</p> <p>EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____</p> <p>PHONE: _____ CELL PHONE: _____</p>
<u>PHYSICIAN AND PHARMACY</u>	<p>LOCAL PHARMACY: _____ PHONE NUMBER: _____</p> <p>FAMILY PHYSICIAN: _____ REFERRING PHYSICIAN: _____</p>
<u>INSURANCE INFORMATION</u>	<p>PRIMARY INSURANCE: _____ POLICY NUMBER: _____</p> <p>POLICY HOLDER'S NAME: _____ RELATIONSHIP: _____</p> <p>POLICY HOLDER'S SOCIAL: ____/____/____ POLICY HOLDER DOB: ____/____/____</p> <p>SECONDARY INSURANCE: _____ POLICY NUMBER: _____</p> <p>POLICY HOLDER'S NAME: _____ RELATIONSHIP: _____</p>

Patient Name: _____

PATIENT MEDICAL HISTORY FORM

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: What is the main reason for your visit today? (Describe your problem in detail)

Please answer the following questions about your present medical problem as it applies to you.

PAIN SEVERITY (IF APPLIES)

If pain is present, circle the number that best describes the level of pain with 10 being the most severe.

0 1 2 3 4 5 6 7 8 9 10

LOCATION

___ Abdomen ___ Back ___ Breast ___ Extremity
___ Chest ___ Head/Neck
Other _____

DURATION

When did you first notice the problem? _____

MODIFYING FACTORS

Does anything help or make the problem worse?

Moving around? Standing up? Lying on my side?

Other? _____

TIMING

How long does the problem last:

ASSOCIATED SIGNS/SYMPTOMS

Is anything else occurring at the same time? Please explain.

CONTEXT

Dull then sharp? Very sharp then leaves? Always there?

QUALITY

Does the problem interfere with your normal functions?

Yes? _____ No? _____ If yes, please explain

PAST MEDICAL HISTORY: Please circle and list dates if you have had any of the following:

		Date:	
Cancer	Y	N	_____
Lymphoma	Y	N	_____
Leukemia	Y	N	_____
Blood Problems	Y	N	_____
Rheumatologic Disease	Y	N	_____
High Blood Pressure	Y	N	_____
Thyroid Problems	Y	N	_____
High Cholesterol	Y	N	_____

			Date:
Diabetes	Y	N	_____
Kidney Disease	Y	N	_____
Tuberculosis	Y	N	_____
Asthma	Y	N	_____
Heart Disease	Y	N	_____
Arthritis	Y	N	_____
Lung Disease	Y	N	_____
Other			_____

Patient Name: _____

Please list all prior hospitalization and surgery. Please do not list any pregnancies and/or births

Reason for admission (Medical reasons or diagnosis)	#1	#2	#3
Month and year hospitalized	_____	_____	_____
Type of Surgery (if one was done)	_____	_____	_____

Have you EVER received radiation treatment for any illness? Yes No

If yes, for what illness? _____

When was the treatment received? _____

Have you EVER received chemotherapy treatment for any illness? Yes No

If yes, for what illness? _____

When was the treatment received? _____

MEDICATIONS:

List all medications, or drugs you currently use or have used at home within the last three months. Include those with a prescription from a doctor, those you bought over the counter in a store, any you received from a friend, any vitamins, home remedies, laxatives or any other product you take to improve your health. If you do not know all this information, please bring all the bottles or boxes with you to your next office visit. (Please attach an additional page if you need more space).

	Name & Strength of Medication	Amount taken	Approximate date started
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

ALLERGIES

List anything (drugs, food, insects, pollen, etc.) you are allergic to:

	Item	Describe reaction you had
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

FOR WOMEN ONLY

Are you currently menstruating? Yes No

If yes, when did your last menstrual period begin? Date ____/____/____

If you are post-menopausal, give approximate date. Date ____/____/____

Please provide the following information:

Number of children born alive	_____
Number of miscarriages	_____
Are you on hormone replacement therapy?	Yes No
Do you have abnormal vaginal bleeding?	Yes No

Patient Name: _____

The following questions are about your FAMILY, you may not know all the information asked. Please answer to the best of your ability.

Please add additional information on the last page.

	LIVING	DECEASED	PRESENT AGE OR AGE AT DEATH	HEATH PROBLEMS	CAUSE OF DEATH IF DECEASED
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____

CHILDREN:

NUMBER OF CHILDREN: _____

First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____
Fourth	_____	_____	_____	_____	_____
Fifth	_____	_____	_____	_____	_____

Any history of cancer, leukemia, or lymphoma in your family? If so, give details: _____

SOCIAL HISTORY:

MARITAL STATUS: _____

What is/was your job position? _____

What are your hobbies? _____

Have you EVER smoked? _____

Do you smoke now? _____

If yes, average number of packs per day? _____

Number of years smoked? _____

Date stopped? _____ Do you desire counseling for smoking cessation? _____

Do you consume alcoholic drinks? _____

If yes, how often? _____

Do you now or have you ever had a problem with alcoholism or drug addiction? _____

If you are reproductive age, do you desire to address fertility in regard to your diagnosis and treatment options? _____

Patient Name: _____

Review of Systems: Do you **CURRENTLY** have or are you **NOW** bothered with the following symptoms? Circle Yes or No

Constitutional Symptoms			Cardiovascular		
Fever	Y	N	Heart pain (Angina)	Y	N
Chills	Y	N	Irregular heart rhythm	Y	N
Fatigue/Excessively Tired	Y	N	Congestive heart failure	Y	N
Weight Loss	Y	N	Varicose veins	Y	N
			Extremity swelling	Y	N
Allergic/Immunologic			Gastrointestinal		
Seasonal allergies	Y	N	Nausea	Y	N
Food allergies	Y	N	Vomiting	Y	N
IV contrast allergies	Y	N	Diarrhea	Y	N
Drug allergies	Y	N	Constipation	Y	N
Eyes			Abdominal pain	Y	N
Sudden visual changes	Y	N	Abdominal swelling	Y	N
Excessive tearing	Y	N	Loss of appetite	Y	N
Eye irritation	Y	N	Indigestion/heartburn	Y	N
Double vision/Blurred vision	Y	N	Blood in bowel movement	Y	N
Ear/Nose/Throat/Mouth			Genitourinary		
Hearing difficulty	Y	N	Blood in urine	Y	N
Dry mouth	Y	N	Painful urination	Y	N
Mouth irritation	Y	N	Frequent urination	Y	N
Sore throat/Hoarseness	Y	N	Hesitation on urination	Y	N
Difficulty Swallowing	Y	N	Incontinence	Y	N
Ear discomfort	Y	N	Sexual dysfunction	Y	N
Sinus problem	Y	N	Genital Mass/tenderness	Y	N
Ringling in the ears	Y	N			
Endocrine			Musculoskeletal		
Hot flashes	Y	N	Joint pain	Y	N
Sweats	Y	N	Swelling/edema	Y	N
Heat intolerance	Y	N	Muscle aches	Y	N
Cold intolerance	Y	N	Bone pain	Y	N
Excessive thirst	Y	N	Decreased range of motion	Y	N
Hematological/Lymphatic			Integumentary		
Easy bruising	Y	N	Skin rash	Y	N
Easy bleeding	Y	N	Lesions	Y	N
Tender lymph nodes	Y	N	Skin breakdown	Y	N
Swollen lymph nodes	Y	N	Persistent itch	Y	N
Breasts			Neurological		
Abnormal breast mass	Y	N	Headaches	Y	N
Nipple discharge	Y	N	Dizzy spells	Y	N
Nipple pain	Y	N	Numbness/tingling	Y	N
			Weakness	Y	N
			Unsteady balance when walking	Y	N
			Tremor	Y	N
Respiratory			Psychological		
Wheezing	Y	N	Are you generally satisfied with your life?	Y	N
Persistent cough	Y	N	Do you feel nervous or anxious?	Y	N
Sputum production	Y	N	Do you have trouble sleeping?	Y	N
Shortness of breath	Y	N	Do you have periods of extreme sadness or crying?	Y	N
Chest pain on breathing	Y	N			
Coughing up blood	Y	N			

The above is true and correct to the best of my knowledge. Patient Signature: _____

Date: ____/____/____