CONFIDENTIAL PATIENT HEALTH RECORD

Date:______________________________

PERSONAL HISTORY

Name:____ Birth Date:______________________ Age:________

Address:____ Sex: Male / Female

City:____________________ State: _______ Zip:_________

Home Phone:____________________________________ Cell Phone:__________________________________

S. S. N. #__________________________________ Driver's License #:___________________________________

Email Address:____

Business Employer:________________________________Occupation:____

Business Phone____

Name of Spouse:____

Spouse's Employer:____

Type of Work:____

Referred to this office by:____

Names & Ages of Children:____

Name & Number of Emergency Contact:____

Relationship:___________________________________

Who is responsible for your bill, you and ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medical ☐ Medicaid

Personal Health Insurance Carrier:____

Health Card I.D. #:______________________________________ Group #:___________________________________

Insured Person's Name:____

Insured Person's Date of Birth:________________________ Insured Person's S.S.N. #:______________________________

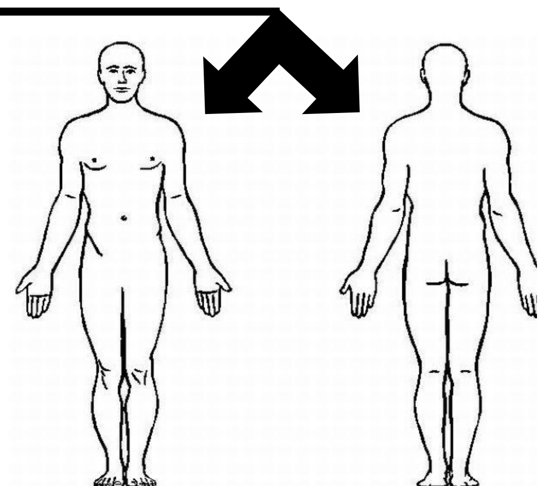
Primary Care Physician:___________________________________ Pharmacy:_____________________________________

CURRENT HEALTH CONDITION

Chief Complaint (why you are here today)____

____

PLEASE PLACE AN "X" ON THE DIAGRAM THE AREA(S) OF DISCOMFORT



When did this condition start?______________________________________

Has it ever occurred before? ☐ Yes ☐ No

Is condition: ☐ Auto Related ☐ Work Related ☐ Other ☐ No injury

Explain:____

Date of Accident:___________________________________

Time of Accident:___________________________________

Complaint/Pain Onset Date:___________________________

If Work: have you filed an injury report with your employer? ☐ Yes ☐ No

Claim #:_______________________________________

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: ☐ None

☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis ☐ Cerebral Palsy ☐ Chicken Pox
☐ Depression ☐ Diabetes ☐ Fetal Drug Exposure ☐ Food Allergies ☐ Headaches ☐ Hepatitis
☐ Measles ☐ Mumps ☐ Rash ☐ Seizure Disorder ☐ Sickle Cell Anemia ☐ Spina Bifada
☐ Unusual Childhood Illnesses

Adult Illnesses: ☐ None

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ CRPS (RSD) ☐ CVA (Stroke)
☐ Depression ☐ Diabetes (Insulin Dep.) ☐ Diabetes (No-Insulin) ☐ Eye Problems ☐ Heart Disease ☐ Hepatitis
☐ Hypertension ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ Psychiatric Problems ☐ Seizures
☐ Shingles ☐ STD's ☐ Suicide Attempts ☐ Thyroid Problems

Surgeries: ☐ None

☐ Angioplasty ☐ Appendectomy ☐ Caesarean Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair ☐ Coronary Bypass
☐ Cosmetic ☐ D&C ☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Joint Reconstruction
☐ Joint Replacement ☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion ☐ Spinal Fusion ☐ Tonsillectomy
☐ Gallbladder
☐ Other ______________________________

Ob/Gyn (Describe): ______________________________
☐ None

Injuries (Describe): ______________________________
☐ None

Immunizations (Describe): ______________________________
☐ None

☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ MMR ☐ Pneumonia
☐ PPD ☐ Small Pox ☐ TD ☐ Varivax

Non-Drug Allergies (Describe): ______________________________
☐ None

FAMILY HISTORY

	Alive	Deceased	Condition:
General Family	☐	☐	______
Father	☐	☐	______
Mother	☐	☐	______
Paternal Grandfather	☐	☐	______
Paternal Grandmother	☐	☐	______
Maternal Grandfather	☐	☐	______
Maternal Grandmother	☐	☐	______
Son(s)	☐	☐	______
Daughter(s)	☐	☐	______
Brother(s)	☐	☐	______
Sister(s)	☐	☐	______

SOCIAL HISTORY

Alcohol: ☐ None ☐ Beer ☐ Liquor ☐ Social Consumption ☐ Wine Amount__________

Diet: ☐ High fat diet ☐ High fiber ☐ High protein ☐ High salt intake
☐ Low calorie intake ☐ Low carbohydrates ☐ Low fiber ☐ Low salt ☐ Low Sugar

Substance: ☐ Denies any ☐ Denies IV drugs Not used since __________ Used Drugs for __________ mos/yrs.

Tobacco: Type: ______________________ Amount: ______________

Education: (level or degree attained): ______________________________

Other doctors seen for this condition? ☐ Yes ☐ No Who? ______________________________

Type of treatment: ______________________ Results: ______________________________

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin ☐ Allergy Medicine ☐ Anti-Depressants ☐ Other: ______________________

Do you wear heel lifts? ☐ Yes ☐ No Side lift? ☐ Yes ☐ No Inter Soles? ☐ Yes ☐ No Arch Supports? ☐ Yes ☐ No Orthotics? ☐ Yes ☐ No

Any other condition you feel we should know about – even if unrelated? ______________________________

____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if "NONE".

System						
Constitutional: ☐ None	☐ Chills	☐ Daytime Somnolence	☐ Fatigue	☐ Fever	☐ Night Sweats	☐ Weight Gain
	☐ Weight Loss					
Eyes/Vision: ☐ None	☐ Blindness	☐ Blurred Vision	☐ Cataracts	☐ Change in Vision	☐ Double Vision	☐ Eye Pain
	☐ Field Cuts	☐ Glasses/Contacts	☐ Glaucoma	☐ Itching	☐ Photophobia	☐ Tearing
ENT: ☐ None	☐ Bleeding	☐ Dentures	☐ Difficulty Swallowing	☐ Discharge	☐ Dizziness	☐ Ear Drainage
	☐ Ear Pain	☐ Fainting	☐ Frequent Sore Throats	☐ Headaches	☐ Hearing Loss	☐ History of Head Injury
	☐ Hoarseness	☐ Loss of Smell	☐ Nasal Congestion	☐ Nose Bleeds	☐ Post Nasal Drip	☐ Runny Nose
	☐ Sinus Infections	☐ Snoring	☐ Ringing in Ears	☐ TMJ		
Respiration: ☐ None	☐ Asthma	☐ Cough	☐ Coughing up blood	☐ Shortness of breath	☐ Sputum Production	☐ Wheezing
Cardio: ☐ None	☐ Angina	☐ Chest Pain	☐ Claudication	☐ Heart Murmur	☐ Heart Problems	☐ Orthopnea
	☐ Palpitations	☐ PND	☐ SOB with Exertion	☐ Swelling of legs	☐ Ulcers	☐ Varicose Veins
Gastro: ☐ None	☐ Abdominal Pain	☐ Belching	☐ Black Tarry Stools	☐ Constipation	☐ Diarrhea	☐ Difficulty swallowing
	☐ Heartburn	☐ Hemorrhoids	☐ Indigestion	☐ Jaundice	☐ Nausea	☐ Rectal Bleeding
	☐ Regurgitation	☐ Stool Caliber	☐ Stool Color	☐ Stool Consistency	☐ Vomiting	☐ Vomiting Blood
Female: ☐ None	☐ Breast lumps/pain	☐ Burning Urination	☐ Cramps	☐ Frequent Urination	☐ Irregular Menstruation	☐ Urine Retention
	☐ Vaginal Bleeding	☐ Vaginal Discharge				
Male: ☐ None	☐ Burning Urination	☐ Erectile Dysfunction	☐ Frequent Urination	☐ Hesitancy/Dribbling	☐ Prostate	☐ Urine Retention
Endocrine: ☐ None	☐ Cold Intolerance	☐ Diabetes	☐ Excessive Appetite	☐ Excessive Hunger	☐ Excessive Thirst	☐ Frequent Urination
	☐ Goiter	☐ Hair Loss	☐ Heat Intolerance	☐ Unusual Hair Growth	☐ Voice Changes	
Skin: ☐ None	☐ Hair Growth	☐ Hair Loss	☐ History of Skin Disorders	☐ Hives	☐ Itching	☐ Nail Texture Changes
	☐ Paresthesias	☐ Pruritis	☐ Rash	☐ Skin Color Changes	☐ Skin Lesions/Ulcers	☐ Varicosities
Nervous: ☐ None	☐ Dizziness	☐ Facial Weakness	☐ Headache	☐ Limb Weakness	☐ Loss of Consciousness	☐ Loss of Memory
	☐ Numbness	☐ Seizures	☐ Sleep Disturbance	☐ Slurred Speech	☐ Stress	☐ Strokes
	☐ Tremor	☐ Unsteadiness of Gait				
Psychologic: ☐ None	☐ Anhedonia	☐ Anxiety	☐ Appetite	☐ Behavioral Changes	☐ Bipolar	☐ Confusion
	☐ Depression	☐ Insomnia	☐ Memory Loss	☐ Mood Change		
Allergy: ☐ None	☐ Anaphalaxis	☐ Food Intolerance	☐ Itching	☐ Nasal Congestion	☐ Sneezing	
Hematology: ☐ None	☐ Anemia	☐ Bleeding	☐ Blood Clotting	☐ Blood Transfusions	☐ Bruising	☐ Fatigue
	☐ Lymph Node Swelling					