PATIENT FILE#_____ **DATE:**_____/_____/_____ revised 3/12

PATIENT INTRODUCTION

All information on this form is required and must be filled out completely before you can be seen; this is our office policy. DO NOT LEAVE ANY BLANK SPACES

Full Legal Name _____ Nick Name:_____
Street Address_____ PO Box#_____ Apt#_____
City_____ State_____ Zip_____
Home Phone _____-_____-_____ Cell Phone:_____/_____/_____ Work Phone_____-_____-_____
E-Mail Address:_____@_____ **Sex** ☐ M ☐ F ☐ Unspecified / **Marital Status** ☐ S ☐ M ☐ D ☐ W

Contact Method: (check one) __ Home Phone __ Cell Phone __ Work Phone __ Email
Birth Date_____/_____/_____ **Age**_____ **SS#**_____-_____-_____
Race: (check one) White__ Black/African American__ Hispanic__ American Indian/Alaskan Native__ Asian__
Asian Indian__ Chinese__ Filipino__ Japanese__ Korean__ Vietnamese__ Native Hawaiian or Pacific Island__
Guamanian or Chamorro__ Samoen__ Other__ I choose not to specify__
Multi-Racial: Yes__ No__ Unknown__
Ethnicity: Hispanic or Latino__ Not Hispanic or Latino__ I choose not to specify__
Preferred Language: English__ Spanish__ American sign__ Chinese__ French__ German__ Hindi__ Urdu__
Armenian__ Japanese__ French__ Persian__ Italian__ Korean__ Vietnamese__ Gujarati__ Tagalog__ Russian__
Polish__ Portuguese__ I choose not to specify__

Verification Question: (check only one question ,then write the answer in that question below)
__ What is the name of your favorite pet? __ In what city were you born? __ What high school did you attend?
__ What is you favorite movie? __ What is your mother's maiden name? __ On what street did you grow up?
__ What was the make of your first car? __ When is your anniversary? __What is your favorite color?
Verification Answer to the chosen question:_____

Place of Employment_____
Status: Employed__ FT Student__ PT Student__ Other__ Retired__ Self Employed__
Employment Address:_____ City _____ State _____ Zip _____
Emergency contact (relative not living with you)_____Relation_____
Street Address:_____/P O Box:_____ City:_____ Zip:_____Phone:_____

Is this accident related: ☐ Yes ☐ No ☐ Auto ☐ Home ☐ Work Date of accident_____/_____/_____
Attorney Name:_____ Address_____ Phone:_____
❖ **STOP and notify the front desk if symptoms are the result of an accident**

How did you hear about our clinic?_____

BILLING AND INSURANCE INFORMATION **(IF PATIENT IS A MINOR GUARANTOR MUST COMPLETE)**
Relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
If insured is other than "self", please complete ALL information below.
Insured's full name:_____ Birthdate_____/_____/_____
Insured's SSN_____/_____/_____ Home Phone_____-_____-_____
Street Address_____ PO Box #_____ Apt # _____City _____ State _____ Zip_____
Insurance Company _____ Insured's ID No._____
Group No._____
Employer _____Work Phone ____-____-____ Shift ☐ 1 ☐ 2 ☐ 3
Address _____City _____ State _____ Zip _____

ADDITIONAL COVERAGE:
Company Name _____Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured's Full Name _____Social Security Number _____-____-_____ Birth date ____/_____/_____
Street Address _____PO BOX # _____ Apt. #_____City _____ State _____ Zip _____
Place of Employment _____ When Hired ____/____/____
Address_____ City_____ State_____ Zip_____

Comprehensive Health History

Date_____

Name:	Date of Birth:	File #:

Chief Complaint (s) THE REASON (S) YOU ARE SEEING THE DOCTOR and Main Health Problems

1.	5.
2.	6.
3.	7.
4.	8.

Have you seen any other doctor(s) for the above problems? __ yes __ no
if yes Please list:

If yes what was the treatment:

Name of your Primary care doctor

PAST MEDICAL HISTORY

Date of last complete physical? Date of last Cholesterol screening?

Has any doctor diagnosed you with Hypertension? If yes what kind?

Has any doctor diagnosed you with Diabetes if yes __ Type1 or __ Type 2

If yes to Diabetes, was your blood lab work test for hemoglobin A1c>9.0% ? __yes __ no __ not sure

Has any doctor diagnosed you with any significant health syndrome presently? __yes __no __ not sure
If yes, what kind?_____

Have you had an X-ray or CT scan or MRI or your low back spine in the past 28 days? __yes __no __

	AIDS or HIV+		Chicken Pox		Measles		Rheumatic Fever				
	Blood or Plasma Transfusion		Epilepsy		Mumps		Scarlet Fever		Prosthetics		
	Cancer		Infectious Mononucleosis		Polio		Whooping Cough		Implants		
Hospital/Surgical History :							Hepatitis A/B/C		Stroke / Heart Disease		

Illness or Operation	Date	Illness or Operation	Date
1)		4)	
2)		5)	
3)		6)	

Past Trauma : (accidents, injuries or falls)	Date		Date
1)		3)	
2)		4)	

Broken Bones : 1) 2)
3) 4) 5)

Allergies : Please List any drug, food, contact or environmental substance to which you have had an allergic or bad reaction.

Medication : Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include dosage amount and times a day you take them. Put Start date if each one
__ NO MEDICATION

1)	4)	7)
2)	5)	8)
3)	6)	9)

Social History :

Occupation:				Marital Status:	
Do you exercise regularly?	Yes	No	What type?		How often?
Do you currently smoke tobacco of any kind?	**Yes**	**No**	**Never been a smoker check this block** ☐	**Former Smoker Check this block** ☐	**Do you use any other type of Tobacco? If yes what type and how often**_____

If you currently smoke any type Tobacco How often do you smoke: __ Current everyday smoker __ Current someday smoker

If you smoke What is the level of interest in Quitting? Please circle: 0 1 2 3 4 5 6 7 8 9 10
no interest very interested

Do you use any form of caffine? How often/How much?	Yes	No	Do you use illicit drugs? How often/how much?	Yes	No	Do you drink alcohol? How often/ how much?	Yes	No
Have you ever been exposed to anyone with tuberculosis?	Yes	No	Have you had excessive exposure to sun from work or recreation?				Yes	No

Patient Name_____

Account #_____ Date_____

To be performed by office staff:
Height:_____inches Weight_____pounds

BP:___/___ Pulse____ Temp____

SPO2 R:_____ L_____

Family History:

	Relationship		Relationship		Relationship
Anemia		Epilepsy		High cholesterol	
Asthma		Glaucoma		Kidney disease	
Obesity		Leukemia		Thyroid disease	
Cancer		Depression		High Blood Pressure	
Diabetes		Heart Disease		Alcohol problems	
Stroke		Lung Disease		Bleeding Tendency	

Present Age or Age of Death :	Mother:	Father:
Sibling #1:	Sibling #2:	Sibling #3:

Men Only : Date of last PSA ? | Date of last rectal exam ?

Women Only : Age of menstrual onset: | Regular? Yes No | Miscarriages: | Age at Menopause:

Pregnancies No. of children: | Born Alive: | Cesarean: | Premature: | Stillbirth: | Miscarriages:

Date of last pap smear? | Date of last mammogram?

Please check or circle all conditions you currently have or have had:

General Questions
- Weight Loss
- Weight Gain
- Change in sleep pattern
- Change in activity capacity

Neurologic & Psychiatric
- Anxiety
- Depression
- Paralysis
- Stroke
- Tremors
- Fainting spells, dizziness
- Head injuries
- Blackouts or near blackouts
- Change in sensation anywhere in the body
- Localized weakness or numbness
- Headaches
- Meningitis
- Seizure
- Tingling
- Memory loss

Ears, Eyes, Nose & Throat
- Hay Fever
- Glaucoma
- Polyps
- Allergy
- Cataracts
- Goiter
- Ear Infection
- Glasses/contacts
- Ear discharge/ pain
- Ringing in the ears
- Frequent nosebleeds
- Swollen glands
- Double Vision
- Hoarseness
- Sinus infection
- Eye problems
- Hearing loss
- Gum problems

Respiratory
- Pleurisy
- Asthma
- Pneumonia
- Prolonged cough
- Shortness of breath
- Loss of breath when lying flat
- Frequent infection (bronchitis)
- Coughing up blood
- Wheezing
- Emphysema
- Tuberculosis

Cardiovascular
- Angina
- Leg Crams
- Heart Attacks
- Ankle swelling
- Awakening at night short of breath & getting out of bed
- Cardiac catheterization
- Cold feet & hands
- Congenital heart disease
- Dizziness when standing up quickly
- High or low blood pressure
- Irregular heart rate
- Purple fingers or lips
- Leg pain that resolves with rest
- Heart palpitations
- Chest Pain
- Murmurs
- Heart Failure
- Varicose Veins

Skin
- Abscess
- Acne
- Boils
- Hives
- Lumps
- Jaundice
- Excessive body odor
- Excessive sweating
- Fungal infections
- Nail problems
- Moles – irregular/change/new
- Dandruff
- Oily skin
- Rashes
- Dry skin
- Psoriasis
- Athlete's foot

Kidneys & Urinary Tract
- Blood in urine
- Kidney disease
- Dribbling after urination
- Painful urination
- Excessive thirst
- Involuntary urination/ incontinence
- Frequent urination (day)
- Frequent urination (night)
- Urine hesitancy/weak flow
- Frequent bladder infections
- Brown urine
- Kidney stone

Endocrine
- Diabetes
- Abnormal body hair
- Changes in skin texture
- Cold/heat intolerance
- History of "borderline" diabetes
- Increased hair loss
- Rheumatism
- Thyroid disease
- Sickle cell

Musculoskeletal
- Anemia
- Back pain
- Gout
- Neck pain
- Abnormal blood counts
- Blood clots in legs/lungs
- Bone marrow biopsy
- Easy bleeding/bruising
- Joint swelling/morning stiffness/muscles aches
- Sciatica
- Arthritis
- Bursitis
- Joint aches
- Tendonitis

Gastrointestinal
- Diarrhea
- Reflux
- Ulcers
- Hepatitis
- Abdominal pain
- Anal fissures
- Vomiting blood
- Black tarry stools
- Problems swallowing
- Liver disease
- Hemorrhoids
- Red blood after bowel Movements
- Gallstones
- Vomiting
- Heartburn
- Indigestion
- Constipation
- Hiatal hernia
- Nausea

Males only
- Hernia
- Bloody ejaculation
- Inability to complete intercourse
- Lump on testicle
- Penile discharge
- Premature ejaculation
- Problems maintaining an erection
- Prostate disease or problems
- Testicular pain or swelling
- Sterility

Females only
- D & C
- Hernia
- PMS
- Ovarian cysts
- Abnormal bleeding btwn. cycles
- Heavy bleeding during cycles
- Abnormal pap smear
- Complications w/pregnancy
- Discharge from breast
- Pelvic inflammatory disease
- Postmenopausal disease
- Vaginal dryness
- Vaginal discharge
- Hot flashes
- Fibroids
- Endometriosis
- Vaginal warts

Male & Female
- Painful sexual intercourse
- Loss of sexual interest
- Unprotected sex
- Groin itching
- Sexually transmitted diseases

NOTES:

PAIN CHART

Name: _____ Account #: _____

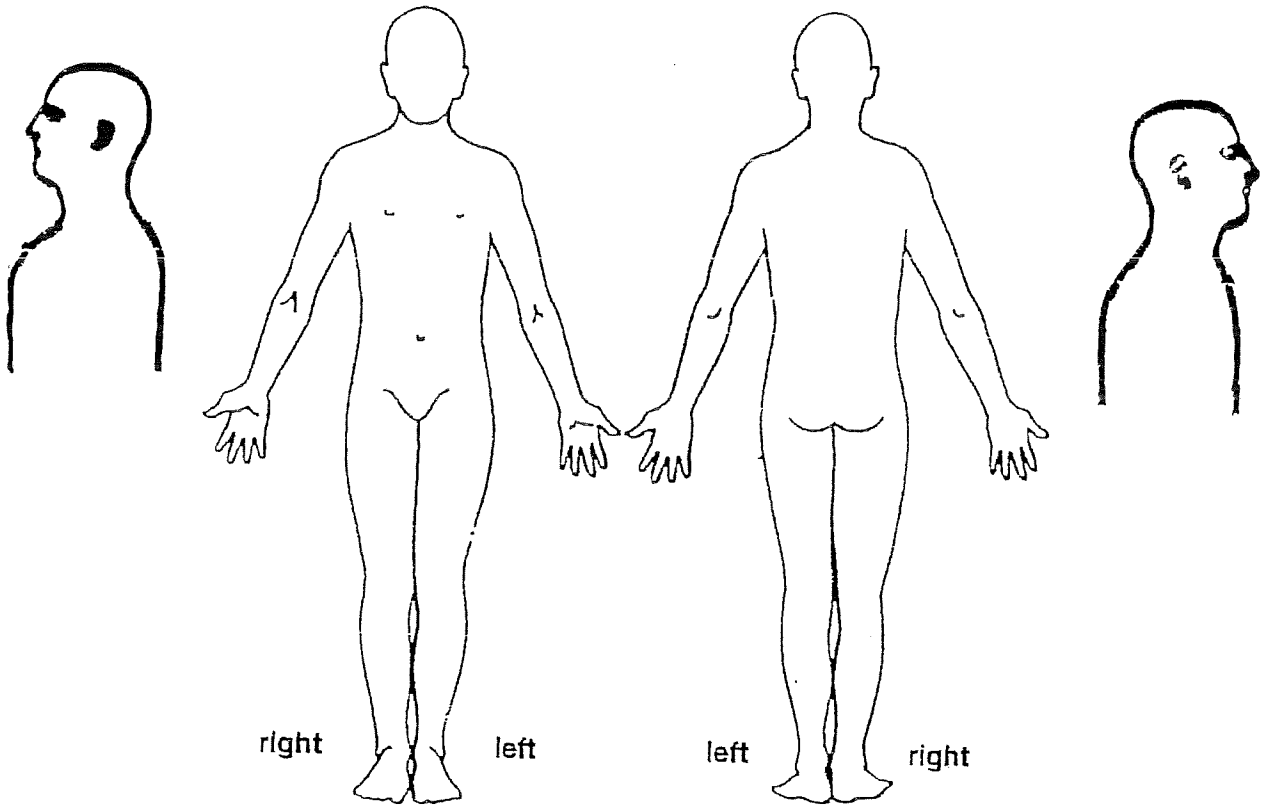
Please describe your condition: _____

_____

_____

Please mark area(s) of injury or discomfort using the appropriate symbols.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
-----	00000	\\\\\	^^^^^	XXXXX



Circle One: Sharp Dull Circle One: Moderate Mild Severe

Doctor's Notes: _____

_____

_____

_____

_____

Patient's Signature: _____ Date: _____