

****WELCOME TO OUR PRACTICE****

Your Full Name _____ Today's Date _____

Age _____ Date of Birth ____ / ____ / ____ SSN ____ - ____ - ____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____
(If Different From Above)

Home Phone (_____) _____ Cell Phone (_____) _____

E-Mail Address _____

Marital Status (Please Circle) Married Single Divorced/Separated Widowed

Referred by _____ (Name) _____

In Case of Medical Emergency Contact _____

Relation to Contact _____ Phone (_____) _____

HIPAA ACKNOWLEDGEMENT

A copy of the Privacy Practices Notice has been provided to me.
(Included in new patient paperwork)

Sign _____ Date _____

PAYMENT INFORMATION

The patient is responsible for any payment/ co-payment due at time of service.

We expect YOU to be familiar with your particular Insurance Plan Benefits. If we are a Participating Provider on your Insurance Plan, you are responsible for any deductibles, coinsurances or co-pay amounts, as well as any services provided that are EXCLUDED by your insurance (i.e. cosmetic surgery, routine services, lab work ect.).

Sign _____ Date _____

NAME _____ DATE _____

SURGERY HISTORY **do not include minor surgery

___ No operations (skip to next question)

1. _____ YEAR _____
2. _____ YEAR _____
3. _____ YEAR _____
4. _____ YEAR _____

MEDICATIONS **current medication

___ No medications (skip to next question)

*Please list all medicine you currently take and reason for taking.

Medication name _____ **Dose/frequency** _____ **Reason** _____

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

ALLERGIES **please list ALL allergies (prescription meds & environmental meds)

___ No allergies (skip to next question)

Allergic to..... _____ **Reaction....** _____

1. _____
2. _____
3. _____
4. _____

NAME _____ DATE _____

FAMILY HISTORY**first degree relatives (father, mother, sister, brother and children)

____ Diabetes ____ Hypertension ____ Anemia ____ Headaches
____ Heart Disease ____ Heart Attack ____ Stroke ____ Epilepsy
____ Thyroid Abnormalities ____ Alcohol/Drug problems
____ Cancer: _____
Other _____

TOBACCO/ ALCOHOL HISTORY

Tobacco use

____ Never
____ Quit previously smoked ____ 1 ____ 2 ____ 3 packs/day for ____ years
____ Yes ____ 1 ____ 2 ____ 3 packs/day for ____ years

Alcohol use

____ Never
____ Social drinker, (describe pattern) _____
____ History of current or past problems with alcohol: _____

SOCIAL HISTORY

Children (if so # of children) _____

Current Occupation or Previous occupation _____

Living Will/ Advanced Directive ____ Yes ____ No

History of Drug use ____ Never ____ Yes: _____

Caffeine use ____ Never ____ cups per day

Hobbies, Sports, Exercise: _____

Travel outside country: _____

Sexuality: ____ Heterosexual ____ Homosexual ____ Bisexual

NAME _____ DATE _____

SYSTEM REVIEW BY CATAGORY

Please mark all that apply with (X)
If uncertain please mark with question mark (?)
If negative please leave blank
If Normal please check normal (X)

GENERAL ___ Normal

___ Major weight changes, appetite loss ___ Major weakness, fatigue, fevers or chills

DERMATOLOGY ___ Normal

___ Significant skin conditions ___ Psoriasis ___ Melanoma
___ Skin lesions, lumps or non-healing sores ___ Other Skin Cancers

HEENT ___ Normal

___ Vision or eye problems ___ Hearing or ear problems ___ Facial Pain
___ Nasal problems or significant nosebleeds ___ Dental, mouth or throat problems

NECK ___ Normal

___ Neck pain, swelling or stiffness

LUNGS ___ Normal

___ Shortness of breath ___ Emphysema ___ Asthma/ wheezing
___ Chronic bronchitis ___ Chronic cough ___ Pneumonia
___ Tuberculosis

CARDIOVASCULAR ___ Normal

___ Hypertension ___ Palpitations or rhythm problems
___ History of heart disease, chest pain, angina, MI, heart attack
___ Shortness of breath with exercise or shortness of breath laying down
___ Arterial or venous impairment, thrombophlebitis, blood clots, feet/ankle swell

NAME _____ DATE _____

GASTROINTESTINAL ___ Normal

___ Swallowing difficulties ___ Abdomen pain ___ Diarrhea
___ Heartburn, indigestion, reflux, ulcers ___ Nausea, vomiting ___ Constipation
___ Colitis or diverticulitis ___ Change in stool, black/bloody
___ Jaundice, turning yellow, liver or gallbladder disease, hepatitis

GENITOURINARY ___ Normal

___ Urinary infections ___ Painful, burning, difficult urination
___ Blood in urine, kidney stones ___ Incontinence/ loss of urine control

MUSCULOSKELETAL ___ Normal

___ Significant arthritis, joint stiffness, muscle pain or weakness
___ Gout ___ Fractures/broken bones

NEUROLOGIC ___ Normal

___ Fainting spells ___ Seizure/epilepsy ___ Migraines, headaches
___ Muscle weakness, paralysis, numbness, tremors ___ Dizziness, vertigo
___ Memory problems, dementia ___ Stroke(s)

PSYCH ___ Normal

___ Severe anxiety depression ___ Suicidal feelings/attempts
___ Psychiatric treatment

ENDOCRINE ___ Normal

___ Thyroid disease ___ Diabetes

HEMATOLOGY/ONCOLOGY ___ Normal

___ Anemia ___ Bleeding
___ Cancers:

WOMEN ___ Normal

___ Breast Problems ___ Vaginal Irritation ___ Abnormal pap/menstrual cycle
___ Sexually transmitted disease-history

MEN ___ Normal

___ Prostate problems ___ Erection problems ___ Sexually transmitted disease-history

(5)