

First Name: _____ Middle _____ Last _____ AKA _____ DOB _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____ Work #: _____
 Email address _____ SS # _____
 **Preferred Method of Contact: Home Cell Work Email
 **May we leave messages about appointments and results? (Check all that apply) No Yes
 Home Cell Work
 Gender: M F Marital Status: _____ Spouse's Name: _____
 Employer: _____ Occupation: _____
 Race/Ethnicity: _____ Primary Language: _____
 Family Physician: _____ Phone #: _____
 Referring Physician: _____ Phone #: _____
 Pharmacy: _____ Phone #: _____
Minor Patients: Child lives with: _____ Contact #: _____
 Mother/Guardian: _____ Contact #: _____
 Father/Guardian: _____ Contact #: _____
Responsible Party, if different than above
 Name: _____ Relationship to Patient: _____
 Primary Insurance: _____ Employer: _____
 Policy Holder: _____ DOB: _____ Relationship: _____
 ID/ SS#: _____ Group #: _____
 Secondary Insurance: _____ Employer: _____
 Policy Holder: _____ DOB: _____ Relationship: _____
 ID/SS#: _____ Group #: _____
 Is today's visit related to an accident? No Yes Date of Accident _____



PATIENT IDENTIFICATION LABEL

If work related, please complete the following questions:

Employer: _____ Address: _____ Phone #: _____

Date of Injury: _____ Claim #: _____

Allowed Diagnosis: _____

MCO: _____ Phone#: _____

Case Manager: _____ Phone#: _____

Have you filed paperwork with your employer? No Yes

Do you have an attorney? No Yes

Name: _____ Phone#: _____

Many of our patients during their recovery may stay with family members, friends or at a rehabilitation or nursing facility. Please provide our office staff with information as to where you are currently staying so we are able to contact you.

I am staying with a: Relative Friend Rehabilitation Center Skilled Nursing Facility

Name of Relative/Friend/ Facility: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have a Health Care Power of Attorney? No Yes

Name of POA: _____ Contact #: _____

(If yes, please provide a copy of the POA documents)

With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical information pertinent to your treatment with this person.

Name: _____ Relationship: _____ DOB _____ Phone #: _____ No Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ No Yes

Name: _____ Relationship: _____ DOB _____ Phone #: _____ No Yes

Patient/Guardian Signature: _____ Date: _____ Time: _____

PATIENT NAME: _____ DOB: _____

Height: _____ Weight: _____

What is the main problem that brings you to our office? _____

PRIOR TESTING: (Pertaining to this visit - Mammograms, MRI, CT ultrasounds, etc.....)

TYPE OF TEST	DATE PERFORMED	FACILITY PERFORMED

PAST MEDICAL HISTORY: Do you (or did you) have any of the following:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Migraine	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Psychiatric Disorder _____
<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Substance Abuse _____
<input type="checkbox"/> Lung Disorder	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Other _____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> AIDS/HIV		

PAST SURGERIES:

YEAR	SURGERY OR ILLNESS	WHERE	SURGEON

MEDICATIONS:

NAME	DOSE	TIMES/DAY	DATE STARTED	DATED ENDED

ALLERGIES: Do you Have a Latex Allergy: Yes No

MEDICATION/FOOD	TYPE OF REACTION

SOCIAL HISTORY:

Tobacco: (Present/Past Use): Yes No Type: Cigarettes Smokeless
 If yes, how many years? _____ Packs/Day? _____ if stopped when? _____
 Alcohol: (Present/Past): Yes No If Yes, # years _____, Drinks/day/week/month? _____
 Quit? _____ if so When? _____
 Caffeine: Amount per day? _____

FAMILY HISTORY:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Migraine	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Cancer
<input type="checkbox"/> Migraine	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Lung Disorder	<input type="checkbox"/> Stroke/TIA's	

Please complete below for any medical conditions indicated above:

Relationship	Age	Living Y/N	Medical Condition and/or Cause of Death

PATIENT MEDICAL HISTORY AND REVIEW OF SYSTEMS: Please indicate Yes (Y) or No (N) in each box.

PATIENT NAME: _____

GENERAL: <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Tired/Fatigued <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Sleep Disturbance	EYES: <input type="checkbox"/> Past eye disorders <input type="checkbox"/> Vision Change/Blurry <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Discharge/Tears <input type="checkbox"/> Light Sensitivity	NEUROLOGIC: <input type="checkbox"/> Headache <input type="checkbox"/> Stroke/Seizures <input type="checkbox"/> Sudden Weakness <input type="checkbox"/> Suddness numbness <input type="checkbox"/> Temporary blindness <input type="checkbox"/> Facial drooping <input type="checkbox"/> slurred speech <input type="checkbox"/> Inability to speak <input type="checkbox"/> Dizziness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Tremors/Shaking <input type="checkbox"/> Difficulty concentrating	INTEGUMENTARY/SKIN <input type="checkbox"/> Suspicious lesions <input type="checkbox"/> Dryness of skin <input type="checkbox"/> Poor wound healing <input type="checkbox"/> Itching <input type="checkbox"/> Changes in skin color <input type="checkbox"/> Flushing <input type="checkbox"/> Rash <input type="checkbox"/> Skin Cancers _____ <input type="checkbox"/> Unusual hair distribution
EARS/NOSE/THROAT: <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ear Pain <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Change in Voice <input type="checkbox"/> Nasal Drip <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sores in/around mouth <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Sore throat		MUSCULOSKELETAL: <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Joint Pain/Swelling <input type="checkbox"/> Fluid on Joints <input type="checkbox"/> Back Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Loss of Strength <input type="checkbox"/> Muscle Aches	NEUROLOGICAL <input type="checkbox"/> Balance issues <input type="checkbox"/> Headaches <input type="checkbox"/> Tremors <input type="checkbox"/> Falling down <input type="checkbox"/> Inability to speak <input type="checkbox"/> Brief Paralysis <input type="checkbox"/> Vision Changes <input type="checkbox"/> Seizures <input type="checkbox"/> Spinning sensations <input type="checkbox"/> Coordination difficulty <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness
CARDIOVASCULAR <input type="checkbox"/> Chest pain/Pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Bluish color lip/nails <input type="checkbox"/> Extremity swelling <input type="checkbox"/> Fatigue <input type="checkbox"/> Stress Test <input type="checkbox"/> Fainting <input type="checkbox"/> Light Headedness <input type="checkbox"/> Leg cramps with exertion <input type="checkbox"/> shortness of breath with exertion		ALLERGIES: <input type="checkbox"/> Persistent Infections <input type="checkbox"/> Hives/Rash <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> HIV Exposure	
LUNGS/RESPIRATORY <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Oxygen use at Home <input type="checkbox"/> Coughing <input type="checkbox"/> Chest discomfort <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Excessive sputum <input type="checkbox"/> Excessive snoring		GENITOURINARY: <input type="checkbox"/> Lack of sexual drive <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Trauma to Genital Area <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Infections <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Burning/Discomfort with urination <input type="checkbox"/> Leaking Urine <input type="checkbox"/> Night urination <input type="checkbox"/> Incomplete bladder emptying <input type="checkbox"/> For Men: <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Testicular pain/swelling <input type="checkbox"/> Penile discharge or Pain <input type="checkbox"/> For Women: <input type="checkbox"/> Foul smelling discharge <input type="checkbox"/> Ovarian/uterine Cancer <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Genital Sores <input type="checkbox"/> Painful urination <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Abnormal cycles	
GASTROINTESTINAL <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal swelling/bloating <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Bowel Problems <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Black/tarry stools <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Colonoscopy? <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Yellowing of skin <input type="checkbox"/> Gas		PSYCHOLOGICAL <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Depression <input type="checkbox"/> Violent thoughts <input type="checkbox"/> Visions/Sounds	
ENDOCRINE: <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Weight Change	HEMATOLOGY: <input type="checkbox"/> Enlarged Lymph Nodes <input type="checkbox"/> Bleeding <input type="checkbox"/> Skin Discoloration <input type="checkbox"/> Abnormal Bruising <input type="checkbox"/> Fevers, unknown cause		
BREAST: <input type="checkbox"/> Breast Mass (Rt or Lt) <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Breast pain <input type="checkbox"/> Abnormal Mammogram <input type="checkbox"/> Breast enlargement			

By signing I attest that the above information is complete, accurate and answered to the best of my knowledge

Patient signature: _____ **Date:** _____

Reviewed by:
Clinical Staff: _____ **Date:** _____

Physician Signature: _____ **Date:** _____