PERSONAL HISTORY

Name: ______________________________ Address: _____________________________________

City: ________________ State: ______ Zip: ___________Birth date: __________ Age: ____________

Home Phone: ____________Cell Phone: ______________Business Phone: __________Sex: ☐ M ☐ F

Social Security ______________ Driver's License No. ___________ Email Address: ________________

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer:___________________________ Type of work: ____________________________

Business Address: ____________________________

Name of Spouse: ____________________________ Spouse's Social Security # ____________________

Type of work: ______________________________

Business Phone: ____________________________

Name and Ages of Children: ____

Who is Responsible for Your Bill, You and ☐ Spouse ☐ Workers Comp. ☐ Auto Insurance ☐ Medicare

Personal Health Insurance (Name)____________________________ Health Card # _________________

CURRENT HEALTH CONDITION

Purpose of This Appointment: ____

Other Doctors Seen For This Condition: ☐ YES ☐ NO Who? _________________________________

Type of Treatment: _________________________Results: ___________________________________

When Did This Condition Begin? _______________ Has This Condition Occurred Before? ☐ YES ☐ NO

Is This Condition ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: ___________________

Date of Accident: ________ Your Auto Insurance Company: ______________ Time of Accident ________

Have You Made a Report of Your Accident to Your Employer? ☐ Yes ☐ No

Drugs You Take: ☐ Nerve Pills ☐ Pain Killers / Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin
☐ Other ____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____________

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PAST HEALTH HISTORY

HOSPITALIZATIONS			***PREGNANCY HISTORY***	
Year	**Hospital**	**Reason for Hospitalization and Outcome**	**Year / Sex of Birth / of Birth**	**Complications, if any**

Major Accidents of Falls: ____

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SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL

☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness
☐ Sweats

MUSCLE/JOINT/ BONE

Pain, weakness, numbness in:

☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

GENITO-URINARY

☐ Blood in urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination

GASTROINTESTINAL

☐ Appetite poor
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood

CARDIVASCULAR

☐ Chest pain
☐ High blood pressure
☐ Irregular heart beat
☐ Low blood pressure
☐ Poor circulation
☐ Rapid heart beat
☐ Swelling of ankles
☐ Varicose veins

EYE, EAR, NOSE, THROAT

☐ Bleeding Gums
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problem
☐ Vision- Flashes
☐ Vision- Halos

SKIN

☐ Bruise easily
☐ Hives
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal

MEN only

☐ Brest lump
☐ Erection difficulties
☐ Lump in testicles
☐ Penis discharge
☐ Sore on penis
☐ Other: ________________

WOMEN only

☐ Abnormal Pap smear
☐ Bleeding between periods
☐ Brest lump
☐ Extreme menstrual pain
☐ Hot flashes
☐ Nipple discharge
☐ Painful intercourse
☐ Vaginal discharge
☐ Other: ________________

Date of last menstrual period ________________________

Have you had a mammogram? ________________________

Are you pregnant? ________________________

Number of children: ________________________

CONDITIONS Check (√) conditions you currently have or have had in the past.

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herpes
☐ High cholesterol
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headache
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Venereal Disease

MEDICATIONS (List medications you are currently taking)	**ALLERGIES** to medications or substances

Pharmacy Name: Phone:

I understand and I agree that health accident insurance policies are an arrangement between an insurance carrier and my self. I authorize this clinic to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. Furthermore, I understand that the Doctor's office will assist me in making my collection. I authorize the direct payment to you of any sum, I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case and/or any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me based in whole or in part upon the charges made for your services.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

____ ________________________________

Patient/ Guardian Signature **Date**