

**PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)**

Mr.  Mrs.  Miss Social Security # \_\_\_\_\_  
NAME \_\_\_\_\_ Driver's License # \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ BIRTHDATE \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_

MARITAL STATUS (✓):  MARRIED  SINGLE  DIVORCED  SEPARATED  WIDOW / ER  MINOR

EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE/PARENT \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

EMPLOYED BY \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WHO TO NOTIFY IN AN EMERGENCY? \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

**↓ MEDICAL INSURANCE INFORMATION** **PATIENT'S MAIL ADDRESS**

HOW DO YOU INTEND TO PAY? (✓):  Cash  Check  Credit Card  Insurance  Medicare  Medicaid or Medi/Cal

NAME OF INSURANCE CO. \_\_\_\_\_ ID # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ GROUP NAME/# \_\_\_\_\_

REASON FOR THIS VISIT:  Illness  Injury  Job Related Injury  Auto Accident  Personal Injury

DATE OF INJURY OR ONSET OF PROBLEM: \_\_\_/\_\_\_/\_\_\_ MAJOR COMPLAINT \_\_\_\_\_

**IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION**

NAME OF RESPONSIBLE PARTY \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

RELATIONSHIP TO THE PATIENT \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_

**↓ IF YOUR INJURY IS JOB RELATED**

NAME OF PERSON WHO CAN AUTHORIZE TREATMENT \_\_\_\_\_

COMPANY'S INSURANCE CARRIER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE CARRIER PHONE NUMBER ( ) \_\_\_\_\_ OK'D BY \_\_\_\_\_

**↓ PLEASE SIGN AND RETURN TO RECEPTIONIST**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
NAME OF INSURANCE CARRIER

\_\_\_\_\_ all surgical and/or medical benefits, if any, otherwise payable to me for ser-  
NAME OF DOCTOR

vices rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date \_\_\_\_\_ Signed \_\_\_\_\_

\*NOTE: Please notify us if any of the above information changes during the course of your treatment.

# HEALTH QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**HISTORY OF PAST ILLNESS:** Have you had

Childhood:

Measles .....No	Yes	Strokes .....No	Yes	Rheumatic fever or heart disease .....No	Yes
Mumps .....No	Yes	Cancer .....No	Yes	Congenital Abnormalities .....No	Yes
Chickenpox.....No	Yes	Tuberculosis .....No	Yes	Other serious diseases.....No	Yes
Diabetes .....No	Yes	Venereal disease .....No	Yes		

Adult:

Have you had any serious illness.....No Yes  
 Have you ever been hospitalized or been under medical treatment for very long .....No Yes  
 If yes, for what reason \_\_\_\_\_

Operations:

Have you ever had surgery..... No Yes  
 List \_\_\_\_\_

Injuries:

Have you had any broken bones.....No Yes  
 Have you had any head concussions or injuries..... No Yes  
 Have you ever been knocked unconscious.....No Yes

Family History:	If Living:		If Deceased:		Has any blood relative ever had:	
	Age	Health	Age (at death) & cause			
Father					Cancer	No Yes
Mother					Tuberculosis	No Yes
Brother/Sister					Diabetes	No Yes
					Heart Trouble	No Yes
					High blood pressure	No Yes
					Stroke	No Yes
Husband/Wife					Convulsions	No Yes
Son/Daughter					Suicide	No Yes
					Mental illness	No Yes
					Bleeding tendency	No Yes
					Gout or other arthritis	No Yes
					Hereditary defects	No Yes

**SOCIAL HISTORY:**

Circle one: Single Married Separated Divorced Widowed  
 Are you living with your husband or wife ..... No Yes  
 Do you have dependents at home ..... No Yes  
 Alcoholic Beverages: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderately \_\_\_\_\_ Daily \_\_\_\_\_ Ever \_\_\_\_\_ No Yes  
 Tobacco: Cigarettes \_\_\_\_\_ Packs a day \_\_\_\_\_ Don't smoke \_\_\_\_\_ Ever smoked \_\_\_\_\_ No Yes  
 Are you employed Full time \_\_\_\_\_ Part time \_\_\_\_\_  
 What is your job \_\_\_\_\_  
 Are you exposed to fumes, dust or solvents \_\_\_\_\_  
 Education: (Years) Grade School \_\_\_\_\_ College \_\_\_\_\_ Postgraduate \_\_\_\_\_  
 How much time have you lost from work because of health during the past:  
 Six months \_\_\_\_\_ One year \_\_\_\_\_ Five years \_\_\_\_\_

**SYSTEMIC REVIEW:** Do you have any of the following?

General:

Recent weight change..... No Yes  
 Have you been in good general health most of your life.... No Yes

SKIN:

Skin Disease.....No Yes  
 Jaundice.....No Yes  
 Hives, eczema or rash.....No Yes  
 Frequent infection or boils.....No Yes  
 Abnormal pigmentation.....No Yes

Head-Eyes-Ears-Nose-Throat:

Eye disease or injury.....No Yes  
 Do you wear glasses.....No Yes  
 Double vision.....No Yes  
 Headaches.....No Yes  
 Glaucoma.....No Yes  
 Itching eyes or nose.....No Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose.....No Yes  
 Nosebleeds.....No Yes  
 Chronic sinus trouble.....No Yes  
 Ear disease.....No Yes  
 Impaired hearing.....No Yes  
 Dizziness or transient episodes of unconsciousness.....No Yes  
Neck:  
 Stiffness.....No Yes  
 Thyroid trouble.....No Yes  
 Enlarged glands.....No Yes  
Respiratory:  
 URI(cold)now.....No Yes  
 Spitting up blood.....No Yes  
 Chronic or frequent cough.....No Yes

**SYSTEMIC REVIEW:**

**Respiratory: (cont'd)**

Asthma or Wheezing..... No Yes  
 Difficulty breathing..... No Yes  
 Any trouble with lungs..... No Yes  
 Pleurisy or Pneumonia..... No Yes

**Cardiovascular:**

Chest pain or angina pectoris..... No Yes  
 Shortness of breath with walking or lying down..... No Yes  
 Difficulty walking two blocks..... No Yes  
 Heart trouble or heart attacks..... No Yes  
 High blood pressure..... No Yes  
 Swelling of hands, feet or ankles..... No Yes  
 Awakening in the night smothering..... No Yes  
 Heart murmur..... No Yes

**Gastrointestinal:**

Peptic ulcer (stomach or duodenal)..... No Yes  
 Vomiting blood or food..... No Yes  
 Gallbladder disease..... No Yes  
 Liver trouble..... No Yes  
 Hepatitis..... No Yes  
 Painful bowel movements..... No Yes  
 Bleeding with bowel movements..... No Yes  
 Black stools..... No Yes  
 Hemorrhoids or piles..... No Yes  
 Recent change in bowel habits..... No Yes  
 Frequent diarrhea..... No Yes  
 Heartburn or indigestion..... No Yes  
 Cramping or pain in the abdomen..... No Yes  
 Does food stick in throat..... No Yes

**Genitourinary:**

Loss of urine..... No Yes  
 Frequent urination..... No Yes  
 Night time urinating..... No Yes  
 Burning or painful urination..... No Yes  
 Blood in urine..... No Yes  
 Kidney trouble..... No Yes  
 Kidney stones..... No Yes  
 Bright's Disease..... No Yes

**Gynecological:**

Age periods started \_\_\_\_\_  
 How long periods last \_\_\_\_\_ Days

**Gynecological: (cont'd)**

Number of pregnancies \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Date of last cancer smear and results \_\_\_\_\_  
 Is there a chance that you are pregnant..... No Yes  
 Frequency of periods, every \_\_\_\_\_ Days  
 Any pain with your periods..... No Yes  
 Number of children \_\_\_\_\_ Ages  
 Date of first day of last period \_\_\_\_\_

**Locomotor-Musculoskeletal:**

Varicose veins..... No Yes  
 Weakness of muscles or joints..... No Yes  
 Any difficulty in walking..... No Yes  
 Any pains in calves or buttocks on walking relieved by rest..... No Yes

**Neuro-Psychiatric:**

Have you ever had psychiatric care..... No Yes  
 Have you ever been advised to see a psychiatrist..... No Yes  
 Do you ever have, or have you had fainting spells..... No Yes  
 Convulsions..... No Yes  
 Paralysis..... No Yes

**Hematologic:**

Are you slow to heal after cuts..... No Yes  
 Blood disease..... No Yes  
 Anemia..... No Yes  
 Phlebitis..... No Yes  
 Have you ever had difficulty with bleeding excessively after tooth extraction or surgery..... No Yes  
 Have you had abnormal bruising or bleeding..... No Yes

**Allergic:**

Any allergies, including medication..... No Yes

**Endocrine:**

Thyroid disease..... No Yes  
 Hormone therapy..... No Yes  
 Any change in hat or glove size..... No Yes  
 Any change in hair growth..... No Yes  
 Have you become colder than before or skin become dryer..... No Yes

HEIGHT \_\_\_\_\_

WEIGHT \_\_\_\_\_

**ALLERGIES AND SENSITIVITIES:**

1. Is there a history of skin reaction or other untoward reaction of sickness following an injection or oral administration of:

Penicillin or other antibiotics.....	Yes	No	Don't Know	What Drug or Food? _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Morphine, Codeine, Demerol or other narcotics.....	Yes	No	Don't Know	
Novocaine or other anesthetics.....	Yes	No	Don't know	
Aspirin, empirin or other pain remedies.....	Yes	No	Don't know	
Sulfa drugs.....	Yes	No	Don't know	
Tetanus antitoxin or other serums.....	Yes	No	Don't know	
Adhesive tape.....	Yes	No	Don't know	
Iodine or merthiolate.....	Yes	No	Don't know	
Any other drug or medication.....	Yes	No	Don't know	
Any foods such as egg, milk or chocolate.....	Yes	No	Don't know	

2. Drugs Recently Taken: Within the past six months has patient taken:

Cortisone.....	Yes	No	Don't know
ACTH.....	Yes	No	Don't know
Anticoagulants.....	Yes	No	Don't know
Tranquilizers.....	Yes	No	Don't know
Hypotensives (high blood pressure medicines).....	Yes	No	Don't know
Has the patient ever received treatment for:			
Asthma, rheumatism or rheumatic fever.....	Yes	No	Don't know
Aspirin.....	Yes	No	Don't know

Source of information, if other than patient: \_\_\_\_\_

Signature of person acquiring this information: \_\_\_\_\_

Doctor

Date

Signature of patient