Confidential Patient Health Record

DATE	I.D NO.

PATIENT HISTORY

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐M ☐F

E-mail Address: _____ Driver's License Number: _____

Social Security # _____ Circle One: Married Single Divorced Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____ Spouse's Social Security # _____

Name of Spouse: _____ Spouse's Social Insurance # _____

Spouse's Employer: _____ Business Phone: _____

Type of Work _____ Names and Ages of Children: _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and ☐Spouse ☐Worker's Comp. ☐Auto Insurance ☐Medicare ☐Medicaid

☐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? _____ Is Condition:

Has This Condition Occurred Before? ☐ Yes ☐ No ☐ Job Related

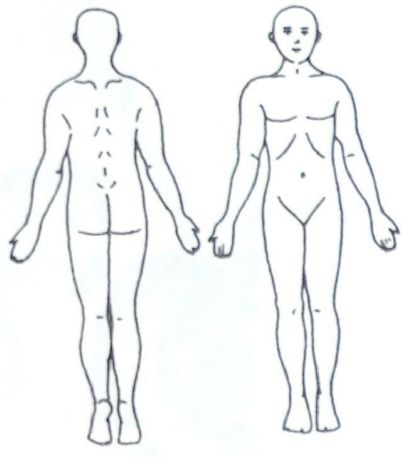
Have You Made A Report of your Accident To Your Employer? ☐ Yes ☐ No ☐ Fall ☐ Home Injury ☐ Auto Accident

Date: _____

☐ Other: _____

Drugs you Now Take:

☐ Nerve Pills
☐ Pain Killers/Muscle Relaxers
☐ Blood Pressure Medicine
☐ Insulin
☐ Other and for what condition: _____



Please Outline on the diagram the area of your discomfort.

Do You Wear A Shoe Lift? Yes No

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

_____

PAST HEALTH HISTORY

Please Check and Describe Major Surgeries/Operations:

☐ Appendectomy ☐ Gall Bladder ☐ Broken Bones
☐ Tonsillectomy ☐ Hernia ☐ Back Surgery
☐ Other: _____

Previous Care:

Doctor's Name: _____

Date of Last Visit: _____

Specialty: _____

Hospitalization (Other Than Above): _____

Significant Trauma (Accidents, Falls, or other): _____

FAMILY HISTORY

Please check & list any family members (Parent, Grandparent, Sister, Brother) who have had any of the following:

☐ Cancer _____ ☐ Stroke _____ ☐ Diabetes _____ ☐ Hypertension: _____
☐ Tumors _____ ☐ Asthma _____ ☐ Heart Disease _____ ☐ Seizures: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Eczema
- ☐ Other _____

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ White Sugar

Drug Use: Never / Type & Frequency _____

Alcohol: Never /Rarely / Moderate / Daily

Cigarettes (e-cigs) Never / Rarely / Moderate

Current Packs/Day _____

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD AND WRITE IN THE DATE IT FIRST & LAST OCCURED:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Concussion Date(s): _____

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose / Sinus Problems

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems High / Low
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

FEMALE ONLY Date of last period: _____

- ☐ Normal Menstruation
- ☐ Painful Menstruation; Describe: _____
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Postmenopausal

Menstrual Amount: Excessive / Normal / Little

- ☐ Discharge; Color: _____

Amount: _____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Number of Pregnancies: _____

Live Births: _____

Premature Births: _____ C-Section: _____

Miscarriage: _____ Abortion: _____

CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU MAY HAVE:

- ☐ Excessive Dreams
- ☐ Cold Hands or Feet
- ☐ Oversleep
- ☐ Swelling of Hands or Feet
- ☐ Poor Memory
- ☐ Easily Awaken
- ☐ Easily Upset
- ☐ Facial Redness
- ☐ Easily Sigh
- ☐ Bitter Taste in Mouth
- ☐ Pain in Ribs
- ☐ Muscle Twitch/Spasm
- ☐ Brittle Nail
- ☐ Ear Ringing
- ☐ Hair Loss
- ☐ Edema (Water Retention)
- ☐ Night Urination
- ☐ Decreased Sex Drive
- ☐ Impotency
- ☐ Loss of Voice
- ☐ Phlegm
- ☐ Skin Problems
- ☐ Sore Throat
- ☐ Spontaneous Sweating
- ☐ Pain with Deep Breath
- ☐ Difficulty Breathing
- ☐ Foul Breath
- ☐ Belching
- ☐ Bruise Easily
- ☐ Loose Stool
- ☐ Indigestion

Bowel Movements: _____ times/day

To the best of my knowledge, the questions of this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status. I also authorize the healthcare staff to perform any necessary services I may need.

Signature (Parent or Guardian if Patient is a minor): **Date:**

DO NOT WRITE BELOW THIS LINE

DIAGNOSIS: ANALYSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Provider's Signature