

Health History Form

All information will remain confidential

Name: _____ Age: _____ Date of Birth: _____ Marital Status: _____ SS#: _____
Gender: M F Home Address: _____ City: _____ State: _____ Zip: _____
Phones: Home# _____ Work# _____ Cell# _____ Best time to reach? AM PM
Best number to use: Home Cell Work Primary Language: English Spanish Other _____
Employer Name: _____ Employer Address: _____
Employer Phone #: _____ Occupation: _____
Emergency contact name: _____ Relationship: _____ Phone #: _____

If patient is a minor, please list:

Father's Name: _____ Father's Employer: _____
Mother's Name: _____ Mother's Employer: _____

Insurance Information

Primary Insurance:

Company Name: _____ Company Address: _____ Phone #: _____
Name of Policy Holder: _____ Policy Holder's DOB: _____ SS#: _____
Identification #: _____ Group #: _____ Copay: _____ Type of Plan: _____

Secondary Insurance:

Company Name: _____ Company Address: _____ Phone #: _____
Name of Policy Holder: _____ Identification #: _____ Group #: _____
Copay: _____ Type of Plan: _____

Workers Compensation

If your employer/ Workers Compensation Carrier has sent you for evaluation/ treatment, please complete the following:

Type of injury sustained: (i.e. broken leg, back pain etc.) _____

Date of Injury: (required) _____ Employer's name and address at time of injury: _____

_____ Contact Name: _____ Contact Phone #: _____

Workers Compensation Carrier: _____ Address: _____

Contact Name: _____ Contact Phone #: _____

Auto Accident

If you are here as a result of an automobile accident, then please fill out the following:

Date of Accident: _____ Describe the injury and or pain that you have: _____

Auto Insurance Company: _____ Address: _____

Phone #: _____ Claim Number: _____

If we are filing your medical claims to your medical insurance company, please fill out the primary insurance information section above. Remember to submit your insurance card to the receptionist so that we may have a copy of your current insurance on record.

Assignment of Insurance Benefits And Authorization to obtain or release patient information

I hereby authorize the physician's office to release such information as may be necessary for claims to the insurance companies listed above. I also hereby authorize payment directly to the physician for any benefits otherwise payable directly to me, but not to exceed the regular charges for this period. I am financially responsible to the above physicians for charges not covered by the assignment. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangements for payment must be made with the business office.

I authorize the physician's office to release or obtain such information as may be necessary to assist in my medical treatment

Signature: _____ Date: _____

Name _____

Symptoms / Systems Review Check the symptoms you currently have or had in the past year)

<p>General:</p> <input type="checkbox"/> None <input type="checkbox"/> Chills / sweats / fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headaches <input type="checkbox"/> Unexplained weight loss <p>Cardiovascular:</p> <input type="checkbox"/> None <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Swelling of Ankles <p>Respiratory:</p> <input type="checkbox"/> None <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Snoring <p>Neurological/Metal Health:</p> <input type="checkbox"/> None <input type="checkbox"/> Learning Disability <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Panic Attack <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Emotional Illness <input type="checkbox"/> Numbness / Tingling: Where? _____	<p>Gastrointestinal:</p> <input type="checkbox"/> None <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bowel changes <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Vomiting blood <p>Genito-Urinary:</p> <input type="checkbox"/> None <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <p>Endocrine:</p> <input type="checkbox"/> None <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive thirst <p>Blood Disorders:</p> <input type="checkbox"/> None <input type="checkbox"/> Bruise easily <input type="checkbox"/> Prior Blood Transfusions	<p>Eye:</p> <input type="checkbox"/> None <input type="checkbox"/> Eye problems <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double vision <p>Ear, Nose, Throat:</p> <input type="checkbox"/> None <input type="checkbox"/> Ear problems <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Loss of balance <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Sinus problems <p>Muscle/Joint/Bone:</p> <input type="checkbox"/> None <input type="checkbox"/> Joint pain: where? _____ <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Limited movement: Where? _____ <p>Skin:</p> <input type="checkbox"/> None <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Sore that won't heal <input type="checkbox"/> Open wound	<p>Men only:</p> <input type="checkbox"/> None <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other <p>Women only:</p> <input type="checkbox"/> None <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump / pain <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Other <p>Date of last: Menstrual period _____ Pap smear _____ Mammogram _____ Are you pregnant? _____ Number of children _____ Number of pregnancies _____ Complications if any _____</p> <p>Other:</p> _____ _____ _____
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All Other Systems are Negative

Health Habits Check which substances you use and describe how much you use.

Alcohol _____
 Illicit drugs _____
 Other _____
 Caffeine _____
 Tobacco _____

Occupational Concerns Check if your work exposes you to the following:

Hazardous Substances
 Heavy lifting
 Stress
 Other _____

Your occupation: _____

Do you live with your family / spouse? _____ If not, will you need assistance after your surgery? _____

Family History (Close blood relatives) Check all that apply

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Neurological
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Mental Illness

Name _____

Conditions / Past Medical History - Check all that apply			
Cardiac <input type="checkbox"/> None <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Disease/ Attack <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood pressure <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Valve Disease <input type="checkbox"/> Pacemaker / ICD (Bring implant card with you) <input type="checkbox"/> Rhythm disturbances	Endocrine <input type="checkbox"/> None <input type="checkbox"/> Diabetes Circle : Diet / Pill / Insulin /Pump <input type="checkbox"/> Thyroid Problems / Goiter <input type="checkbox"/> Adrenal disease Cancer or Tumor <input type="checkbox"/> None <input type="checkbox"/> Type _____ <input type="checkbox"/> Chemo _____ <input type="checkbox"/> Radiation _____	Musculoskeletal <input type="checkbox"/> None <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Limited movement <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Back / neck Problems <input type="checkbox"/> Fractures <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Myasthenia Gravis	Bleeding / Circulation <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Blood clots / DVT <input type="checkbox"/> Poor circulation <input type="checkbox"/> Phlebitis <input type="checkbox"/> Sickle Cell
Respiratory <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema / COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP - Y / N? <input type="checkbox"/> TB	Genitourinary <input type="checkbox"/> None <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate/testicle problem <input type="checkbox"/> Urinary Tract Infection	Skin <input type="checkbox"/> None <input type="checkbox"/> Rashes: Where? _____ Breast <input type="checkbox"/> None <input type="checkbox"/> Lumps <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Breast Pain <input type="checkbox"/> Abnormal Mammogram	Infectious Diseases <input type="checkbox"/> None <input type="checkbox"/> History of Wound Infection <input type="checkbox"/> Recent Mono <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C Diff
Neurological/Mental Health <input type="checkbox"/> None <input type="checkbox"/> Stroke / Mini (TIA) <input type="checkbox"/> Seizures <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Depression / Anxiety <input type="checkbox"/> Paralysis <input type="checkbox"/> Back Disc Disorder	Gastrointestinal <input type="checkbox"/> None <input type="checkbox"/> Reflux <input type="checkbox"/> Hernia <input type="checkbox"/> Ulcers <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver disease	Hearing & Vision <input type="checkbox"/> None <input type="checkbox"/> Hearing loss <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataract	Implantable Devices <input type="checkbox"/> None <input type="checkbox"/> Ports/Pumps <input type="checkbox"/> Other (list) Important! Bring implant card with you.
Surgical History - Check all that apply			
<input type="checkbox"/> No prior surgery <input type="checkbox"/> Amputation <input type="checkbox"/> Aneurysm (AAA) <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Carotid	<input type="checkbox"/> Cataract L R <input type="checkbox"/> Colon Resection <input type="checkbox"/> Cysto <input type="checkbox"/> D & C <input type="checkbox"/> Fem/Pop Bypass <input type="checkbox"/> Gallbladder <input type="checkbox"/> Heart Bypass <input type="checkbox"/> Heart Cath.	<input type="checkbox"/> Heart Valve <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Kidney removal <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Mastectomy L R <input type="checkbox"/> Pacemaker / AICD	<input type="checkbox"/> Prostate <input type="checkbox"/> Sinus <input type="checkbox"/> Spine (Back/Neck) <input type="checkbox"/> Splenectomy <input type="checkbox"/> Tonsils & Adenoids <input type="checkbox"/> Total Hip L R <input type="checkbox"/> Total Knee L R <input type="checkbox"/> Tubal Ligation List any other:
Allergies - Check all that apply			
<input type="checkbox"/> Codeine <input type="checkbox"/> Demerol	<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa	<input type="checkbox"/> Morphine <input type="checkbox"/> Aspirin	<input type="checkbox"/> Novocaine <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Iodine <input type="checkbox"/> Seafood <input type="checkbox"/> Latex <input type="checkbox"/> Foods _____ <input type="checkbox"/> Adhesive/Tape <input type="checkbox"/> None
Other:			

Name _____

Other Physicians Please list all physicians that are presently treating you.		
Primary Care Physician _____ Office # _____ Date Last Seen _____	Cardiologist _____ Office # _____ Date Last Seen _____	Other Physician(s)
History of Present Illness		
What is the reason for your visit? _____		
When did you first notice the problem? _____	Have you had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the problem painful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you treated for this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location? _____	Does it interfere with regular activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Intensity of the pain: 0 1 2 3 4 5 6 7 8 9 10	Character of the pain: (circle those that apply): Sharp Dull Constant Intermittent	
What makes it worse? _____		
What makes it better? _____		
Have you recently experienced: <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Weight loss <input type="checkbox"/> Night sweats		
Comments:		
Information provided by _____ Relationship to Patient _____ Date _____		

Name _____

Medications List all medications with dosage you are currently taking (including over the counter, inhalers, eye drops, aspirin, herbs) or attach a list of your medications

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Taken Prednisone / Steroids on regular basis in last year? Yes No

Current Immunizations: Tetanus _____ Pneumonia _____ Flu _____

Pharmacy Name: _____ Number: _____

Anesthesia	Yes	No	?	Comments
Have you ever had anesthesia?				
Have you ever had a problem with anesthesia including malignant hyperthermia or difficulty placing breathing tube?				
Has any member of your family had a problem with anesthesia?				
Loose, capped or broken teeth: bridges or dentures?				
Trouble opening mouth or jaw clicking?				
Do you have problems with limited neck mobility?				
Do you have shortness of breath after walking up 1 flight of stairs?				
Do you smoke?				# packs per day ____ # years ____
Are you an ex-smoker? When stopped?				# packs per day ____ # years ____
Do you drink alcoholic beverages?				How often ____ how much ____
Do you use any street drugs?				
Have you ever had a blood transfusion?				If "yes", what year(s)?
Do you have problems with chronic pain?				
Any religious/cultural practices we should know about ?				
Do you have an advanced directive (living will)?				
Females: Is there a chance you could be pregnant?				