

**Patient’s Personal History & Health Assessment**

**Date: \_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_**

**Weight \_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Race:\_\_\_\_\_\_\_\_\_ Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Soc. Sec. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State:\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_**

**Communication Preference: \_\_\_\_\_Email \_\_\_\_\_\_ US Mail \_\_\_\_\_Home phone**

**\_\_\_\_\_Cell phone \_\_\_\_\_ Work Patient Portal**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nearest Relative/kin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_**

**Zip Code: \_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Last Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Equipment:** *(Please mark all that applies to you)*

**Do you use a Cane \_\_\_\_\_\_ Oxygen \_\_\_\_\_\_\_ Walker \_\_\_\_\_\_\_ Wheelchair \_\_\_\_\_\_\_ Nebulizer \_\_\_\_\_**

**Do you own or rent this equipment? \_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use Glasses? \_\_\_\_ Yes \_\_\_\_ No Date of last eye Exam? \_\_\_\_\_\_\_**

**Hearing Aid \_\_\_\_\_**

**Social History:**

**Alcohol \_\_\_\_\_ Smoking \_\_\_\_\_\_ Drugs \_\_\_\_\_\_ Other \_\_\_\_\_\_\_**

**Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:**

**\_\_\_\_ Married \_\_\_\_ Widowed \_\_\_\_Single \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_\_\_Live Alone**

**Immunizations:**

**\_\_\_ Pneumococcal \_\_\_\_ Rubella \_\_\_\_ Tetanus \_\_\_ Influenza \_\_\_\_ Diptheria \_\_\_Other**

**Family History:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Alive** | **Dead** | **Age** | **Cause of Death** |
| **Mother** |  |  |  |  |
| **Father** |  |  |  |  |
| **Brother** |  |  |  |  |
| **Sister** |  |  |  |  |

**Living Arrangements Yes No**

**Do you own your home \_\_\_\_ \_\_\_\_**

**Do you rent your home? \_\_\_\_ \_\_\_\_**

**Do you live alone? \_\_\_\_ \_\_\_\_**

**Do you have a will? \_\_\_\_ \_\_\_\_**

**Do you have a living will? \_\_\_\_ \_\_\_\_**

**Do you need other legal assistance? \_\_\_\_ \_\_\_\_**

**Do you have an Advanced Directive? \_\_\_\_ \_\_\_\_**

**Do you have surrogate decision letter? \_\_\_\_ \_\_\_\_**

**Personal Habits**

**Have you ever smoked tobacco? \_\_\_ Yes \_\_\_ No**

**Are you a regular smoker now? \_\_\_ Yes \_\_\_ No**

**Number of cigarettes per day \_\_\_\_\_\_ \_\_\_\_ Cigars \_\_\_\_ Pipe**

**How long have you been smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of years**

**Check if you regularly drink: Social/ occasional drinker**

**Hard liquor \_\_\_\_ 1-3 oz. per day \_\_\_\_ Over 3 oz. per day**

**Beer \_\_\_ 1 bottle per day \_\_\_\_ 2 bottles \_\_\_ 3 or more**

**Wine \_\_\_ 1 glass per day \_\_\_\_ 2 glasses 3 or more**

**Dou you drink coffee? \_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_3 or more cups**

**Do you exercise?**

**Regularly \_\_\_ Occasionally \_\_\_\_ Rarely \_\_\_\_**

**Have you used any of the following:**

**\_\_\_ Marijuana \_\_\_LSD \_\_\_\_Heroin \_\_\_ Cocaine \_\_\_ Speed**

**\_\_\_\_Other similar substances**

|  |  |  |
| --- | --- | --- |
| **Lifestyles (optional)** | **Yes** | **No** |
| **Are you sexually active?** |  |  |

**If yes, please answer the following questions:**

**Sexual preference**

|  |  |  |
| --- | --- | --- |
| **Partner same sex** | **Yes** | **No** |
| **Partner opposite sex** |  |  |
| **Partners of both sexes** |  |  |
| **Do you consistently use contraceptives** |  |  |

|  |  |  |
| --- | --- | --- |
| **Activities of Daily Living** | **Yes** | **No** |
| **Do you use a catheter for urine?** |  |  |
| **Do you have a problem using the toilet?**  **(for urination bowel movement)** |  |  |
| **Do you drive?** |  |  |

|  |  |  |
| --- | --- | --- |
| **Occupational** | **Yes** | **No** |
| **Are you presently employed?** |  |  |
| **Does or did your work involve unusual work, exposure to dust, noise, radioactivity etc.?** |  |  |
| **Are you limited at work because of disability?** |  |  |
| **Are you retired?** |  |  |

**Types of work you have done:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

**Have you recently lived or traveled outside the U.S.**

**\_\_\_ Yes \_\_\_No**

**Do you eat less than three meals a day?**

**\_\_\_ Yes \_\_\_\_ No**

**Do you have special food customs or restrictions?**

**\_\_\_ Yes \_\_\_\_ No**

**Do you use any community services now?**

**\_\_\_ Yes \_\_\_\_ No**

**Check** if you have/had any of the following illnesses. If unsure, leave blank:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Condition/Illness** | **Self** | **No** | **Relative** | **Not Sure** |
| **Alcohol overuse** |  |  |  |  |
| **Allergies (other than medication)** |  |  |  |  |
| **Anemia** |  |  |  |  |
| **Arthritis** |  |  |  |  |
| **Asthma** |  |  |  |  |
| **Bleeding Tendency** |  |  |  |  |
| **Cancer** |  |  |  |  |
| **CVA/TIA** |  |  |  |  |
| **Colitis** |  |  |  |  |
| **Heart Disease (CHF, CAD,MI)** |  |  |  |  |
| **Depression/Anxiety** |  |  |  |  |
| **Diabetes** |  |  |  |  |
| **Dialysis** |  |  |  |  |
| **Emphysema/COPD/Bronchitis** |  |  |  |  |
| **Epilepsy** |  |  |  |  |
| **Frequent Kidney/Bladder infection** |  |  |  |  |
| **Frequent Lung Infections** |  |  |  |  |
| **Gallbladder Disease** |  |  |  |  |
| **Cardiac Arrhythmias/**  **pacemaker** |  |  |  |  |
| **Gout** |  |  |  |  |
| **Heart Attack** |  |  |  |  |
| **High Cholesterol** |  |  |  |  |
| **Hepatitis** |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |
| **Intestinal Polyps** |  |  |  |  |
| **Jaundice** |  |  |  |  |
| **Leukemia** |  |  |  |  |
| **Headaches** |  |  |  |  |
| **Nervous Break Down** |  |  |  |  |
| **Radiation or Chemotherapy** |  |  |  |  |
| **Rheumatic Fever** |  |  |  |  |
| **Sexually Transmitted Disease** |  |  |  |  |
| **Sickle Cell Anemia** |  |  |  |  |
| **Stomach Ulcers** |  |  |  |  |
| **Stroke** |  |  |  |  |
| **Suicide Attempt** |  |  |  |  |
| **Thyroid** |  |  |  |  |
| **Tuberculosis** |  |  |  |  |
| **Sleep Apnea** |  |  |  |  |

**Childhood Illness: (** Check if you have/had any of the following illnesses. If unsure, leave blank:**)**

**Measles** \_\_\_\_\_\_ **Mumps** \_\_\_\_\_ **Chicken Pox** \_\_\_\_\_ **Hay Fever** \_\_\_\_ **Other** \_\_\_\_\_

**Operations**/ **Surgeries** : List and Indicate approximate year.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Serious Injuries**: (other than the above) List and Indicate approximate year.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations**: (other than operations)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: Do you take the following

\_\_\_\_**Aspirin, Bufferin, Anacin, Tylenol** or similar product

\_\_\_\_ **Motrin, Advil**

**\_\_\_\_** Vitamins \_\_\_\_ Other prescription or over the counter drugs

**List each drug or medication, its amount and how often you take it.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **Allergic** to any medications? \_\_\_ Yes \_\_\_ No

If yes, please list the medications and the reaction you had with them:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any **environmental** or **food allergies**? \_\_\_\_ Yes \_\_\_\_No

If yes, please list them and the reaction you had to them:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE BRING ALL YOUR MEDICATION YOU’RE TAKING TO EVERY APPOINTMENT**

Please check “YES” to the following questions ONLY if the problem is of significant concern in the past (1 month) or unless the question specifically states “EVER

**REVIEW of SYSTEMS:**

|  |  |  |
| --- | --- | --- |
| **General** | **YES** | **NO** |
| Do you usually feel persistently tired or worn out? |  |  |
| Have you recently been drinking more waters or fluids? |  |  |
| Has there been any unusual weight gain or loss recently? |  |  |

|  |  |  |
| --- | --- | --- |
| **Cardiovascular** | **YES** | **NO** |
| Do you have pain, tightness or pressure in the front or back of your chest? |  |  |
| Have you been told your electrocardiogram was abnormal? |  |  |
| Do you have swelling in your feet or ankles? |  |  |
| Does your heart ever beat fast or irregularly? |  |  |
| Do you have cramps in the calf muscles when you walk? |  |  |
| Do your fingers or toes ever get cold, become numb, or get very white or bluish? |  |  |

|  |  |  |
| --- | --- | --- |
| **Central Nervous System** | **YES** | **NO** |
| Dou you often have spells of dizziness, faintness or lightheadedness? |  |  |
| Do you have frequent headaches? |  |  |
| Have you recently fainted, blacked out, lost consciousness? |  |  |
| Have you ever wanted to commit suicide? |  |  |
| Do you ever hear voices or see people when no one is around? |  |  |
| Do you have trouble remembering recent  events? |  |  |
| Do you ever have convulsions or fits? |  |  |
| Have you ever wanted to commit suicide? |  |  |
| Do you ever hear voices or see people when no  one is around? |  |  |

|  |  |  |
| --- | --- | --- |
| **Eyes** | **Yes** | **No** |
| Do you experience pain in your eyes? |  |  |
| Did you have glaucoma or cataract? |  |  |
| Have you experienced changes in your vision? |  |  |
| Have you experienced halo around lights? |  |  |

|  |  |  |
| --- | --- | --- |
| **ENT: (Ear, Nose, Throat)** | **Yes** | **No** |
| Do you have any trouble hearing? |  |  |
| Do you have ringing or buzzing in your ears? |  |  |
| Do you have earaches or discharge from your  ears? |  |  |
| Do you have drainage down the back of your  throat? |  |  |
| Do you have frequent or sever nosebleeds? |  |  |
| Do you have persistent hoarseness? |  |  |

|  |  |  |
| --- | --- | --- |
| **Gastrointestinal** | **Yes** | **No** |
| Have you recently had any changes in your  eating habits? |  |  |
| Have you recently noted any trouble in  swallowing? |  |  |
| Do you have a lot of indigestion or heartburn? |  |  |
| Have you ever vomited blood? |  |  |
| Are you bothered with constipation? |  |  |
| Do you have frequent loose stools or diarrhea? |  |  |

|  |  |  |
| --- | --- | --- |
| **Skin** | **Yes** | **No** |
| Do you have any changes in the color of your skin? |  |  |
| Do you have any rashes or itching? |  |  |
| Do you have any growths or lumps on your skin? |  |  |
| Do you have any sores or wounds that do not heal? |  |  |
| Do you have any changes in the color or size of warts or moles? |  |  |

|  |  |  |
| --- | --- | --- |
| **Genitourinary** | **Yes** | **No** |
| Do you have burning or pain when you urinate? |  |  |
| Do you have to pass water frequently? |  |  |
| Do you have to get up at nights? |  |  |
| Do you have trouble with loosing urine when you cough or sneeze? |  |  |
| Have you ever passed blood in your urine? |  |  |
| Have you ever had an operation to prevent  pregnancy?  (Vasectomy or sterilization, such as tubal  ligation) |  |  |
| Have you had herpes? |  |  |

|  |  |  |
| --- | --- | --- |
| **Musculoskeletal** | **Yes** | **No** |
| Do you have joint pain or stiffness (arthritis)? |  |  |
| Do you ever have a problem with back pain? |  |  |
| Does your back pain interfere with your work or activities? |  |  |
| Do you have trouble walking or using your hip, knee joints? |  |  |

|  |  |  |
| --- | --- | --- |
| **Respiratory** | **Yes** | **No** |
| Do you have frequent chest colds or  pneumonia? |  |  |
| Do you have a constant or bothersome cough? |  |  |
| Do you have blood when you cough? |  |  |
| Do you have difficulties breathing? |  |  |
| Do you have wheezing in your chest? |  |  |

|  |  |  |
| --- | --- | --- |
| **Women Only** | **Yes** | **No** |
| Did you have any pregnancies? |  |  |
| Total number of pregnancies? |  |  |
| Have you had any lumps in your breast? |  |  |
| Have you had any abnormal bleeding from the vagina in the past year? |  |  |
| Have you passed the menopause or change? |  |  |
| Do you have any prolapse(falling out)of the vagina or uterus? |  |  |
| Have you had a hysterectomy? |  |  |
| Do you have any vaginal drainage? |  |  |
| **Men** Only: Do you have prostate gland trouble? |  |  |

**PAIN ASSEESSMENT:**

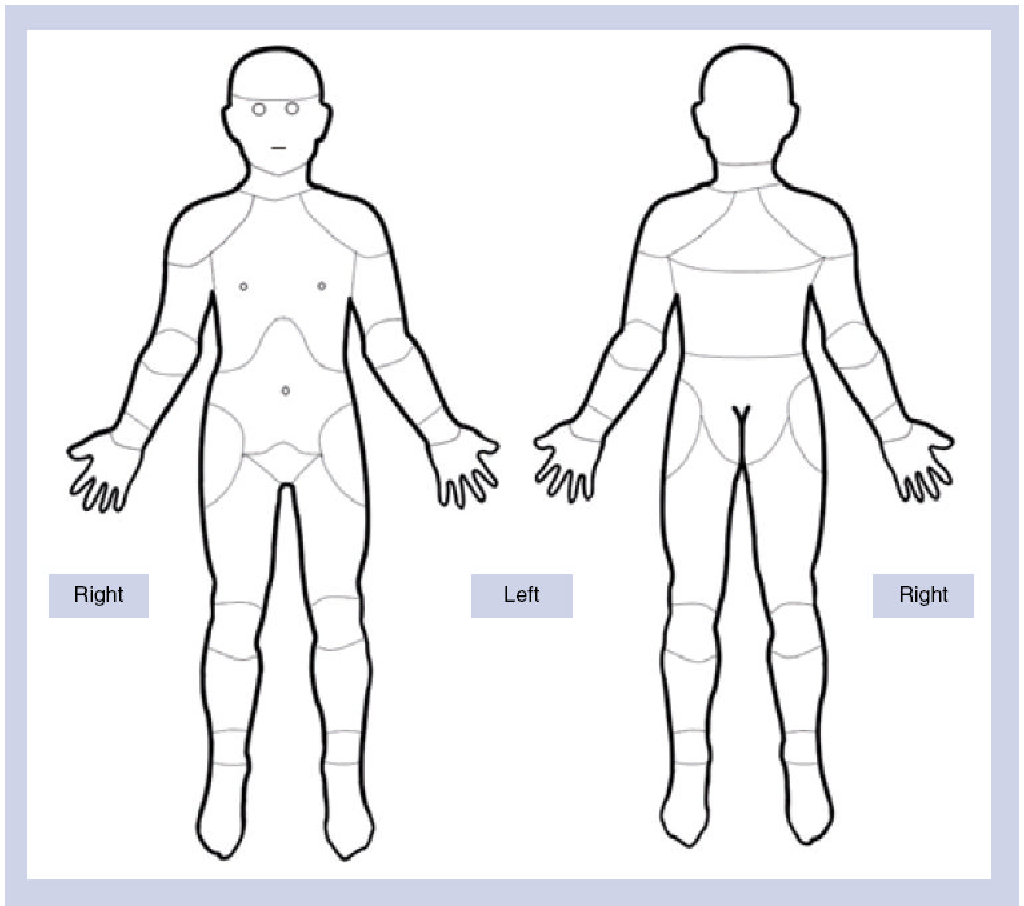
PAIN: YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_ LOCATION: \_\_\_\_\_\_\_\_\_\_

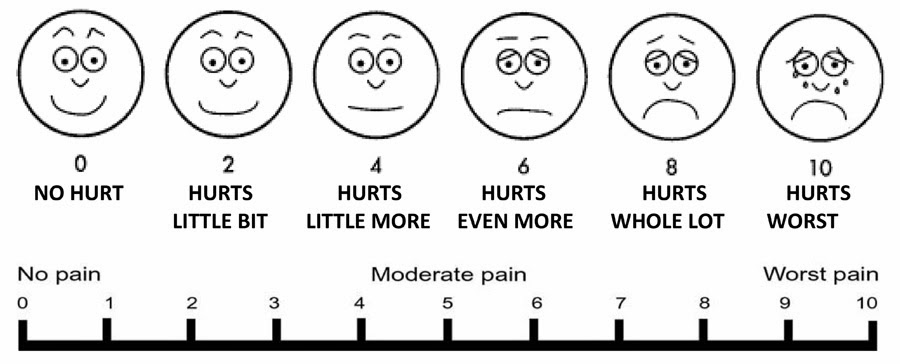
COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TREATMENT PLAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please draw where the primary pain is located using the diagram below:





**CONSENT FOR TREATMENT**

I HEREBY CONSENT TO AND AUTHORIZE A PHYSICIAN / NURSE PRACTITIONER AND/OR ANY HEALTH CARE PROFESSIONAL AT YOU & I PRIMARY CARE, AESTHETICS AND WELLNESS TO PERFORM A

PHYSICIAL EXAMINATION, DIAGNOSTIC PROCEDURE(S) AND TO PRESCRIBE A THERAPEUTIC REGIMEN. I HEREBY AUTHORIZE THE PHYSIAN(S) AND/OR NURSE PRACTITIONER OF YOU & I PRIMARY CARE, AESTHETICS AND WELLNESS TO RELEASE/COLLECT INFORMATION INCLUDING DIAGNOSIS ACQUIRED IN THE COURSE OF MY EXAM TO/FROM ANY HEALTHCARE FACILITIES, PHYSICIANS, OR INSURANCE CARRIERS.

PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I HAVE BEEN GIVEN A COPY OF THE PRIVACY PRACTICES AND I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW IT.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION AND RELEASE**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­

Who is Responsible for this Account: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_/ \_\_\_\_\_\_\_ (MM/DD/YYYY)

Social Security Number: \_\_\_\_\_\_\_, \_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Id: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient covered by additional insurance? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Id: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Assignment and Release**

I certify that I have insurance with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , and assign directly to You & I Primary Care, Aesthetics and Wellness and all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor / nurse practitioner may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to You & I Primary Care, Aesthetics and Wellnes, for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Guardian or Personal Representative Date

Printed Name of Patient, Guardian or Personal Representative Relationship to Patient

Assignment of Benefits Form

**Financial Responsibility**

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

**Assignment of Benefits**

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other auto/health/medical plan, to issue payment check(s) directly to You & I Primary Care, Aesthetics and Wellness medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Authorization to Release Information**

I hereby authorize You & I Primary Care, Aesthetics and Wellness to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from You & I Primary Care, Aesthetics and Wellness on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature Date

Witness Date

**CANCELLATION AND NO SHOW POLICY**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will allow another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $50.00 cancellation fee.

Patients who do not show up for their office or blood work appointment without a call to cancel will be considered as NO SHOW. Patients who No-Show Two (2) or more times in a 12 month period may be dismissed from the practice and denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician and/or Nurse Practitioner /patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Office Manager: Leinier Rodriguez

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient or Patient’s Representative