



Medical History Form

PATIENT INFORMATION

Name _____
Last Name, First Name, Initial, Nickname DOB _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Phone _____

Optional: Are you Spanish/Latino? Yes No

Race: African American or Black Asian Caucasian or White Hawaiian or Other Pacific Island Decline Other

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____ Who referred You? _____

Prior Primary Care Physician: _____

In case of emergency, who should be notified? _____ Phone _____

SOCIAL HISTORY

How many children do you have? _____	What are the ages of your children? _____
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Female to Male <input type="checkbox"/> Male to Female	Yes No
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	Tobacco use <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Cigarettes <input type="checkbox"/> Smokeless
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	Alcohol use <input type="checkbox"/> <input type="checkbox"/> If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Occasional
Lives <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Family	Drug use <input type="checkbox"/> <input type="checkbox"/>
Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how often?	<input type="checkbox"/> If yes, describe: Seatbelt use all the time? <input type="checkbox"/> Yes <input type="checkbox"/> No

ADVANCE DIRECTIVE

Advanced Directive discussed? Yes No

Living Will? Yes No

Power of Attorney? Yes No

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ DOB _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Group # _____ Policy# _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ DOB _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____ Group # _____ Policy# _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not covered by insurance

Responsible Party Signature

Relationship

Date

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Notice of Privacy Practices (Patient Initials) _____ I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information and for the purposes described in the practice's Notice of Privacy Practices.

Release of Information (Patient Initials) _____ I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: * Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. * Obtain payment from designated third-party payers. * Conduct normal health care operations such as quality assessments or evaluations and physician certifications. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time.

Disclosures to Friends and/or Family Members I give permission for my Protected Health Information to be disclosed by phone, fax or in person for purposes of picking up prescriptions, communicating results, findings, and care decisions to the family members and others listed below:

Table with 3 columns: Name, Relationship, Contact Number

This release will remain in effect until it is revoked in writing by the patient

Signature of Patient or Personal Representative

Date

FAMILY HISTORY (check all that apply)

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGY LIST

Allergy	Type of Reaction

MEDICATION REVIEW (Dose, Frequency, Route)

(Please specify if over-the-counter, prescription, vitamin(s), herbal)

CHRONIC CONDITIONS

<input type="checkbox"/> Abnormal Heart Rhythm	<input type="checkbox"/> COPD / Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> Abnormal PAP Smear	<input type="checkbox"/> <i>with exacerbation</i>	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Anemia	<input type="checkbox"/> <i>without exacerbation</i>	<input type="checkbox"/> Fracture*	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> <i>Vertebral</i>	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> <i>Femur</i>	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Benign Prostatic Hyperplasia/BPH	<input type="checkbox"/> Diverticula	<input type="checkbox"/> <i>Pelvic</i>	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Dementia	<input type="checkbox"/> GERD/ Reflux	<input type="checkbox"/> IBS/Irritable Bowel Syndrome
<input type="checkbox"/> Cancer List: _____	<input type="checkbox"/> DVT / Blood Clots	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Kidney Failure/ Dialysis
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes Mellitus*	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Chronic Kidney Disease*	<input type="checkbox"/> <i>without Complications</i>	<input type="checkbox"/> Gout	<input type="checkbox"/> Lupus
<input type="checkbox"/> <i>Stage I (GFR 90+)</i>	<input type="checkbox"/> <i>with Complications</i>	<input type="checkbox"/> Hypertension*	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> <i>Stage II (GFR 60-89)</i>	<input type="checkbox"/> <i>with Ophthalmic Disease</i>	<input type="checkbox"/> <i>with CHF</i>	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> <i>Stage III (GFR 30-45)</i>	<input type="checkbox"/> <i>with Renal Disease</i>	<input type="checkbox"/> <i>with Kidney Disease</i>	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> <i>Stage IV (GFR 15-29)</i>	<input type="checkbox"/> <i>with Neuropathy</i>	<input type="checkbox"/> Head/Spinal Injuries	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> <i>Stage V (ESRD)</i>	<input type="checkbox"/> <i>with PVD</i>	<input type="checkbox"/> Malignancy*	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> <i>Long Term Use of Insulin</i>	<i>Specify</i>	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Drug/Alcohol Dependence	<input type="checkbox"/> Headache/Migraines	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Constipation	<input type="checkbox"/> Eczema	<input type="checkbox"/> Old MI/ Heart Attack/CAD	OTHER:

SURGERY HISTORY

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Transplant
<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Carotid Artery Balloon/Stent	<input type="checkbox"/> C-Section	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> OTHER:

SPECIALIST OR OTHER TREATING PHYSICIAN(S)-CARE PROVIDER(S)

PROVIDER NAME	PROVIDER SPECIALTY-PROVIDER TYPE	TREATMENT DESCRIPTION