

# Confidential Patient Health Record

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

How did you hear about us?  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  
 Close to home/work  Dr. \_\_\_\_\_  Yellow pages  Drove by  Hospital  Insurance Plan

## Personal Information

Title:  Mr.  Ms.  Mrs.  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Suffix:  Jr  Sr  II  III  
Birth Date: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  Separated  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

## Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

## Employment Information

Business Name: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer's Email Address: \_\_\_\_\_  
Occupation/Job Title: \_\_\_\_\_ Job Description \_\_\_\_\_

## Current Health Condition

Unwanted Condition (Why you are here today?): \_\_\_\_\_  
\_\_\_\_\_

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

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

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

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**



**Key: A=Ache B=Burning N = Numbness  
P=Pins & Needles S=Stabbing**

When did this Condition BEGIN? \_\_\_\_/\_\_\_\_/\_\_\_\_

Has it ever occurred before?  Yes  No. When? \_\_\_\_\_

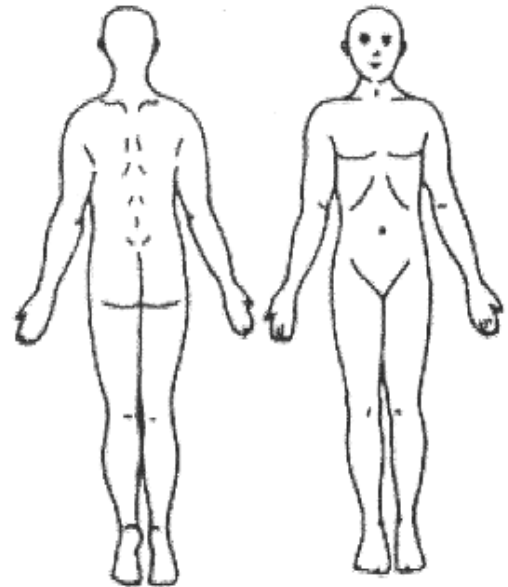
Is the Condition:  Auto Related  Job Related  Home Injury  
 Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am /pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?  
\_\_\_\_\_  
\_\_\_\_\_



**REVIEW OF SYSTEMS** -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

**Constitutional:**  I DENY having or have had any of the symptoms or problems listed below.

- chills  fatigue  night sweats  weight loss
- daytime drowsiness  fever  weight gain

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- blindness  change in vision  field cuts  photophobia
- blurred vision  double vision  glaucoma  tearing
- cataracts  eye pain  itching  wear glasses/contacts

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- bleeding  ear drainage  hearing loss  nosebleeds  sore throat
- dentures  ear pain  history of head injury  postnasal drip  tinnitus (ringing in ears)
- difficulty swallowing  fainting  hoarseness  rhinorrhea (runny nose)  TMJ problems
- discharge  frequent sore throats  loss of sense of smell  sinus infections
- dizziness  headaches  nasal congestion  snoring

**Respiration:**  I DENY having any of the symptoms or problems listed below.

- asthma  coughing up blood  sputum production
- cough  shortness of breath  wheezing

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

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

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> shortness of breath with exertion or exercise |
| <input type="checkbox"/> chest pain                        | <input type="checkbox"/> low blood pressure  | <input type="checkbox"/> swelling of legs                              |
| <input type="checkbox"/> claudication (leg pain/ache)      | <input type="checkbox"/> orthopnea (difficulty breathing lying down)                           | <input type="checkbox"/> ulcers  |
| <input type="checkbox"/> heart murmur                      | <input type="checkbox"/> palpitations  | <input type="checkbox"/> varicose veins                                |
| <input type="checkbox"/> heart problems                    | <input type="checkbox"/> paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) |  |

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain       | <input type="checkbox"/> diarrhea              | <input type="checkbox"/> indigestion     | <input type="checkbox"/> abnormal stool caliber     | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching             | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice        | <input type="checkbox"/> abnormal stool color       |   |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn             | <input type="checkbox"/> nausea          | <input type="checkbox"/> abnormal stool consistency |   |
| <input type="checkbox"/> constipation         | <input type="checkbox"/> hemorrhoids           | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting                   |   |

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> birth control     | <input type="checkbox"/> cramps             | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding  |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy              | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy    | <input type="checkbox"/> urine retention        |  |

**Male:**  I DENY having any of the symptoms or problems listed below.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> burning urination    | <input type="checkbox"/> frequent urination   | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention   |

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance   | <input type="checkbox"/> excessive hunger                | <input type="checkbox"/> goiter           | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes           | <input type="checkbox"/> excessive thirst                | <input type="checkbox"/> hair loss        | <input type="checkbox"/> voice changes       |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance |  |

**Skin:**  I DENY having any of the symptoms or problems listed below.

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss                 | <input type="checkbox"/> itching      | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color   | <input type="checkbox"/> hives                     | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities          |
| <input type="checkbox"/> hair growth             | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash         |  |

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> dizziness       | <input type="checkbox"/> limb weakness         | <input type="checkbox"/> numbness          | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor                                |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures          | <input type="checkbox"/> stress         | <input type="checkbox"/> unsteadiness of gait/ loss of balance |
| <input type="checkbox"/> headache        | <input type="checkbox"/> loss of memory        | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes        |  |

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- |   |  |                                      |                                      |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia                  | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety                    | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression  | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion         | <input type="checkbox"/> insomnia    |                                      |

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis      | <input type="checkbox"/> itching                | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash                     |                                   |

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia   | <input type="checkbox"/> blood clotting    | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue         |  |



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

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

**Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- back injury
- broken bones
- disability (ies)
- fall (severe)
- fracture
- head injury (loss of consciousness)
- head injury (no loss of consciousness)
- industrial accident
- joint injury
- laceration (severe)
- motor vehicle accident
- soft tissue injury (mild)
- soft tissue injury (moderate)
- soft tissue injury (severe)
- other: \_\_\_\_\_

**Family History: Mark all that apply below. List any specific conditions past or present after has/had:**

- |                      |                                |                                   |   |   |   |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

**Social History**

- Alcohol:  Never  Social Consumption only  Beer  Liquor  Wine ; \_\_\_\_\_ oz \_\_\_\_\_ glasses;  Day  Week  Month
- Diet (please mark all that apply):  High Fat  High Fiber  High Protein  High Salt  
 Low Calorie  Low Carb  Low Fiber  Low Salt  Low Sugar
- Education (please mark the highest level completed):  Preschool  Elementary  Middle  Junior High  Votech  
 In High School  Did Not Finish High School  High School Diploma  Post High School Classes  Assoc/Technical Degree  
 In College  College Degree  In Graduate School  Graduate Degree  Doctorate  Other: \_\_\_\_\_
- Drugs:  Deny any illegal drug use  Deny use of IV drugs  Have not used drugs since \_\_\_\_\_  Have used drugs for \_\_\_\_\_
- Tobacco:  Deny Tobacco Use  Do not smoke cigars, cigarettes or pipe  Live with a smoker  Quit smoking  
 Smoke; # \_\_\_\_\_ per  Day  Week  Month  Chew; # \_\_\_\_\_ cans per  Day  Week  Year

**Insurance Information:**

- Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es))  Myself ONLY
- Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Other (be specific): \_\_\_\_\_
- Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_
- Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_
- Policy Holder's Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Workers Compensation Injury / Auto / Personal Injury:**

- Have you filed an injury report with your employer?  Yes  No Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ am/pm
- Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_
- Carriers Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_
- Claim #: \_\_\_\_\_

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

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

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

**Patient Print Name:** \_\_\_\_\_

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

**Patient's Signature:** \_\_\_\_\_

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