Patient History

Name (Last, First): ______________________________ Gender: M / F

Date of Birth: ______________________ Social Security Number: ______________________

Address: ____

City: ____________________ State: __________ Zip Code: ________________

Phone Number(s): (H) ______________ (C) ________________(W)________________

E-Mail ____

What is the doctor's name that referred you here? ______________________________

What are the symptoms that brought you to our center? ______________________________

____

When did this first occur? ____

Were you injured? YES / NO

If yes, specify when and how: ____

Medical History: (Circle one)

Diabetes	YES / NO	Glaucoma	YES / NO
Liver Disease	YES / NO	Sickle Cell	YES / NO
Hypertension	YES / NO	Kidney Disease	YES / NO
Hepatitis	YES / NO	HIV Positive	YES / NO
Heart Disease	YES / NO	Stroke	YES / NO
Seizures	YES / NO	Asthma	YES / NO

Other, please list type: ____

History of Cancer: YES / NO

If yes, treatment type for cancer? ____

Do you have any known allergies? YES / NO

If yes, list all known allergies: ____

____

I.V. Enhancement/Iodine allergy? YES / NO

If yes, explain reaction: ____

____

Are you taking any medications? YES / NO

If yes, list all medication you are on and have taken today: ______________________________

____

Pertaining to today's visit have you had any of the following exams?

Cat Scan	YES / NO	MRI	YES / NO
X-ray	YES / NO	Ultrasound	YES / NO

If yes, when? ____

Where? ____

Results? ____

Have you ever had any surgeries? YES / NO (Circle one)

If yes, list and date all surgeries: ____

____

Female Patients only:

Date of last menstrual period: ____

Are you pregnant? YES / NO Total Pregnancies: ________________________

Miscarriage? YES / NO If yes, how many? ________________________

Tubal Ligation? YES / NO

Have you had a hysterectomy? YES / NO

If yes, were your ovaries removed? YES / NO If yes, which one? ________________________

Do you have an IUD? YES / NO

Do you use Birth Control Pills? YES / NO

Insurance Patients only*:

Insurance Name: ____

Policy Holder's Name: ________________________________ Relation to Patient: ________________

Date of Birth: ____________________ Social Security Number: ________________________________

***NOTE**: Policy Holder's information is necessary for claims purposes.

Race: African ____ American Indian or Alaskan Native _____ Asian _____ Caucasian _____ Pacific Islander ______ Other ________________

Ethnicity: Hispanic ______ Non-Hispanic _________

Language: ____

Patient Record of Disclosure

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

REPORTS WILL AUTOMATICALLY BE FAXED TO REFERRING PHYSICIAN'S OFFICE

Person(s) other than your referring doctor or yourself authorized to receive your medical information:

____

Name of person(s)/Relation

____ _______________________

Emergency Contact Name | Emergency Contact Phone

______ I DO NOT AUTHORIZE MY MEDICAL INFORMATION TO BE DISCLOSED TO ***ANY OTHER*** PARTIES EXCEPT MY DOCTOR AND ME.

I acknowledge that all of the above information is correct.

____ _______________________

Signature of Patient | Date