HEALTH QUESTIONNAIRE

REASON FOR VISIT

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) High cholesterol
2) Migraine	7) Hayfever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) High blood pressure	20)

HOSPITAL ADMISSIONS *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION

ALLERGIES

SUPPLEMENTS

VACCINE	YEAR OF LAST	VACCINE	YEAR OF LAST
Tetanus / Td		MMR Measles Mumps Rubella	
Influenza (flu)		Meningitis	
Pneumonia		Chicken pox	
Hepatitis A		HPV	
Hepatitis B		Shingles	
Whooping C			

MEDICAL HISTORY *MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.*

Decreased hearing
Ringing in ear
Ear infections - *frequent*
Dizzy spells Fainting spells
Failing vision Eye pain
Date of last eye exam
Double or blurred vision
Nose bleeds Sinus trouble
Sore throats - *frequent*
Hoarseness - *prolonged*
Hayfever / Allergies
Pneumonia / Pleurisy
Bronchitis / Chronic cough
Asthma / Wheezing
Date of last TB test
Shortness of breath:
on exertion lying flat
in the past week
affects work / lifestyle
Chest pain High blood pressure
Date of last cholesterol test
Heart murmur Swollen ankles
Irregular pulse Palpitations
Leg pain - *when walking*
Varicose veins / Phlebitis
Cold numb feet
Loss of appetite - *recent*

Difficulty swallowing
Heartburn Peptic ulcer
Aspirin - Arthritis - Pain pills
Nausea/Vomiting Gallbladder prob
Jaundice / Hepatitis
Irritable bowel syndrome
Abdominal pain
Bloating / discomfort
Diarrhea Constipation
Diverticulosis Crohn's Colitis
Inflammatory bowel disease
Bloody or tarry stools
Test for blood in stools
Hemorrhoids Hernia
Urination - Overactive Bladder
Overnight more than twice
More than 8 times / 24 hrs.
Urgency to urinate with leakage
Decrease in force/flow Painful
Stress incontinence — urine leakage with exercise / movement
Blood in urine Kidney stones
Urine infections - *frequent*
Bed wetting
Weight loss / gain Appetite
Anemia Bruise easily
Blood transfusions

Cancer Easily fatigued
Decreased energy / endurance
Diabetes Thyroid disease
Seizures Stroke
Tremor / hands shaking
Headaches Numbness
Arthritis / Rheumatism
Bone fracture / joint injury
Osteoporosis Back pain
Foot pain Gout
Rashes Hives
Psoriasis Eczema
Excessive sweating
Concentration problems
Depression Nervousness
Agitation Memory loss
Moodiness Suicidal thoughts
Feelings of worthlessness
Phobias Mental illness
Sleep problems - how long
How frequent
Waking refreshed
Rheumatic fever Scarlet fever
Chickenpox Polio Mumps
Measles German measles
Tuberculosis Herpes

Aids / Hiv Std
Sexually transmitted diseases - # of encounters
Sexual problems / enjoyment
Decreased work performance
Alcohol oz. per week
Coffee / Tea cups per day
Smoking - cig/day # years
year quit
Exercise
Street drugs
Travel abroad

MALES - Prostate problems

FEMALES - *Please complete*
Menstrual flow:
Reg. Irreg. Pain / Cramps
Days of flow Length of cycle
Date — 1st day of last period
Number of:
Pregnancies Abortions
Miscarriages Live births
Birth control method
B.C. pill (name)
Flushing / Menopause
Pain / Bleeding during or after sex
Migraine with nausea
Date of last Pap test
normal abnormal
Date of last mammogram
normal abnormal

NOTES

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PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

PAGE #

CHART #

NAME | MARITAL STATUS S | M | W | D | SEP | DATE OF BIRTH | DATE

STREET ADDRESS | CITY STATE, ZIP

PHONE # - HOME ( ) | WORK # ( ) | OCCUPATION/ EMPLOYER

SPOUSE'S NAME | DATE OF BIRTH | OCCUPATION/ EMPLOYER | PHONE # ( )

IF UNDER 18 **PARENT / GUARDIAN**

EMERGENCY CONTACT (OTHER THAN SPOUSE) | PHONE # ( ) | ADDRESS | RELATION

S.S. # | DRIVER'S LICENSE # | REFERRED BY

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT) | RELATIONSHIP

BILLING ADDRESS | PHONE # ( )

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY | ADDRESS | EFFECTIVE DATE

NAME OF INSURED | RELATION TO PATIENT | GROUP# | BENEFIT CODE

I.D.#

2) INSURANCE COMPANY | ADDRESS | EFFECTIVE DATE

NAME OF INSURED | RELATION TO PATIENT | GROUP# | BENEFIT CODE

I.D.#

MEDICARE I.D.# | MEDICAID I.D.#

OTHER COVERAGE

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. ______ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME *(please print)* ______ DATE ______

PARENT / GUARDIAN *(please print)* ______ SIGNATURE ______

HIPAA COMPLIANT

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