

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____

Birth Date: _____ Age: _____

Address: _____

Sex: Male / Female

City _____ State: _____ Zip: _____

Home Phone: _____

Social Security #: _____

Cell Phone: _____

Driver's License #: _____

E-mail Address: _____

Business Employer: _____

Fax #: _____

Occupation: _____

Business Phone: _____

Name of Spouse: _____

Spouse's Employer: _____

Type of Work: _____

Names & Ages of Children: _____

Referred To This Office By: _____

Relationship: _____

Name & Number of Emergency Contact: _____

Who is Responsible for your bill, you and Spouse Worker's Comp Auto Insurance Medicare Medicaid

Personal Health Insurance Carrier: _____

Health Card ID #: _____

Insured Person's Name: _____

Group #: _____

Insured Person's Date of Birth: _____

Primary Care Physician: _____

Insured Person's Social Security #: _____

Pharmacy: _____

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) _____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? Yes No

Is condition: Auto Related Work Related Other No Injury

Explain: _____

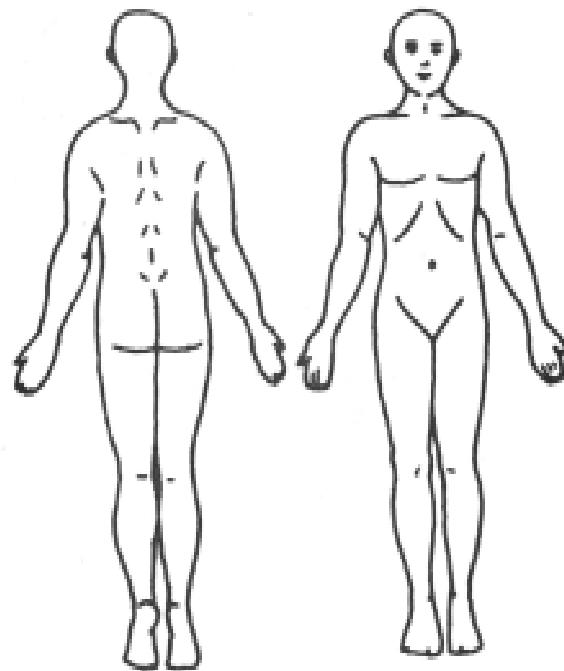
Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work: Have you filed an injury report with your employer? Yes No

Claim #: _____



PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

- Childhood Illness:** ADD Allergies/Hayfever Asthma Atopic Dermatitis Cerebral Palsy Chicken Pox
 None Depression Diabetes Fetal Drug Exposure Food Allergies Headaches Hepatitis
 Measles Mumps Rash Seizure Disorder Sickle Cell Anemia Spina Bifida
 Unusual Childhood Illnesses _____

- Adult Illnesses:** Anemia Arthritis Asthma Cancer Chicken Pox CRPS (RSD)
 None CVA (Stroke) Depression Diabetes (Insulin Dep) Diabetes (NIDDM - Noninsulin) Eye Problems Heart Disease
 Hepatitis Hypertension Kidney Disease Liver Disease Lung Disease Psychiatric Problems
 Seizures Similar Symptoms STD's Suicide Attempts Thyroid Problems

- Surgeries:** Angioplasty Appendectomy Caesarean Section Cardiac Catheterization Carpal Tunnel Repair Coronary Bypass
 None Cosmetic D&C Hemorrhoidectomy Hernia Repair Hysterectomy Joint Reconstruction
 Joint Replacement Laminectomy Mastectomy Pacemaker Insertion Spinal Fusion Tonsillectomy
 Gallbladder
 Other _____

Ob/Gyn: Describe: _____
 None

Injuries: Describe: _____
 None

- Immunizations:** Flu Hepatitis A Hepatitis B Hepatitis C MMR Pneumonia
 None PPD Small Pox TD Varivax

Non-Drug Allergies: Describe: _____
 None

FAMILY HISTORY

	Alive	Deceased	Condition
General Family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Son(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Daughter(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Alcohol: None Beer Liquor Social Consumption Wine Amount _____

Diet: High Fat Diet High Fiber High Protein High Salt Intake
 Low Calorie Intake Low Carbohydrate Low Fiber Low Salt Low Sugar

Education: Level or Degree Attained: _____

Substance: Denies Any Denies IV Drugs Not Used Since _____ Used Drugs For _____

Tobacco: Type _____ Amount _____

Other doctors seen for this condition? Yes No Who? _____

Type of treatment: _____ Results: _____

Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers Blood Pressure Medicine Insulin Allergy Medicine
 Anti-Depressants Other: _____

Do you wear heel lifts? Yes No Side Lift Yes No Inter Soles Yes No Arch Supports Yes No
Orthotics Yes No

Any other conditions you feel we should know about - even if unrelated? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if “NONE”.

Constitutional: Chills Daytime Somnolence Fatigue Fever Night Sweats Weight Gain
 None Weight Loss

Eyes/Vision: Blindness Blurred Vision Cataracts Change in Vision Double Vision Eye Pain
 None Field Cuts Glasses/Contacts Glaucoma Itching Photophobia Tearing

ENT: Bleeding Dentures Difficulty Swallowing Discharge Dizziness Ear Drainage
 None Ear Pain Fainting Frequent Sore Throats Headaches Hearing Loss History of Head Injury
 Hoarseness Loss of Smell Nasal Congestion Nose Bleeds PND (Post Nasal Drip) Rhinorrhea (Runny Nose)
 Sinus Infections Snoring Tinnitus (Ringing in Ears) TMJ

Respiration: Asthma Cough Coughing up Blood Shortness of Breath (SOB) Sputum Production Wheezing
 None

Cardio: Angina Chest Pain Claudication Heart Murmur Heart Problems Orthopnea
 None Palpitations PND SOB with Exertion Swelling of Legs Ulcers Varicose Veins

Gastro: Abdominal Pain Belching Black Tarry Stools Constipation Diarrhea Difficulty Swallowing
 None Heartburn Hemorrhoids Indigestion Jaundice Nausea Rectal Bleeding
 Regurgitation Stool Caliber Stool Color Stool Consistency Vomiting Vomiting Blood

Female: Breast Lumps/Pain Burning Urination Cramps Frequent Urination Irregular Menstruation Urine Retention
 None Vaginal Bleeding Vaginal Discharge

Male: Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate Urine Retention
 None

Endocrine: Cold Intolerance Diabetes Excessive Appetite Excessive Hunger Excessive Thirst Frequent Urination
 None Goiter Hair Loss Heat Intolerance Unusual Hair Growth Voice Changes

Skin: Changes in Nail Texture Changes in Skin Color Hair Growth Hair Loss History of Skin Disorders Hives
 None Itching Paresthesias Pruritis Rash Skin Lesions/Ulcers Varicosities

Nervous: Dizziness Facial Weakness Headache Limb Weakness Loss of Consciousness Loss of Memory
 None Numbness Seizures Sleep Disturbance Slurred Speech Stress Strokes
 Tremor Unsteadiness of Gait

Psychologic: Anhedonia Anxiety Appetite Behavioral Change Bipolar Confusion
 None Depression Insomnia Memory Loss Mood Change

Allergy: Anaphalaxis Food Intolerance Itching Nasal Congestion Sneezing
 None

Hematology: Anemia Bleeding Blood Clotting Blood Transfusions Bruising Fatigue
 None Lymph Node Swelling