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Patient Information & Release Form

Name: _____
First Middle Last
Address: _____
Street City State Zip
Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Social Security Number: _____
Sex: _____ Single: _____ Married: _____ Divorced: _____ Widowed: _____ Pets: _____
Employer: _____ Occupation: _____
Employer's Address: _____
Referred By: _____
Spouse or closest relative: _____
His/Her phone number: _____ Relationship: _____
Person responsible for bill: _____
Person who will act as your healthcare advocate if needed:
Name: _____ Phone: _____
Do you have any Advanced Directives/Living Will: Yes _____ No _____
If so, please provide a copy for your chart.
Pharmacy name and location: _____
Do we have your permission to:
Leave a message on your answering machine at home? _____ Email? _____
Leave a message at your place of employment? _____
Discuss your medical condition with any member of your household? _____
If yes, with whom? _____ Relationship: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT 1/1/18

The undersigned acknowledges receipt of the Notice of Privacy Practices
Required by HIPPA

Signed by: _____
_____ Date: _____
Printed patient name

E-mail address: _____

Past Medical History

Please check if you have had any of the following conditions or have had them in the past

Cardiovascular
___High Blood Pressure
___ High Cholesterol
___ Heart Attack
___ Heart Disease
Requiring Stent
___ Heart Murmur
___ Heart Failure
___Stroke/TIA
___ Arrhythmia

Gastrointestinal
___ Gastritis
___ Peptic Ulcer
___ Crohn/Colitis
___ Hemorrhoids
___ Gallstones
___ Colon Polyps
___ Colon Cancer

Pulmonary
___ Asthma
___ Bronchitis/Chronic
___ Pneumonia
___ Tuberculosis
___Emphysema
___ Lung Cancer

Genitourinary
___ Urinary Tract Inf
___ Venereal Disease
___ Abnormal Pap
___ Prostate Issues
___ Kidney Disease
___ Kidney Stones

Endocrinology
___ Diabetes
___ Osteoporosis
___ Thyroid Disorder

Heme
___ Anemia
___ Bleeding Disorder
___ Blood Transfusion

Autoimmune Disease
___ Lupus
___ Arthritis
___ Psoriasis

Neuro/Mental Health
___ Epilepsy
___ Alzheimer's Disease
___ Psychiatric Disorder
___ Anxiety
___ Depression
___ Migraines

Other
___ Glaucoma
___ Cataracts
___ Alcohol/Drug Abuse
___ Rheumatic Fever
___ Allergies
___ Breast Cancer
___ Breast Lumps
___Skin Cancer
___Other Cancer

Please list any other medical problems you have that are not listed above.

_____ _____
_____ _____

Past Hospitalizations

Reason for Hospitalization Date

_____
_____
_____
_____
_____

Past Surgical History

Please list any you have had in the past

Reason for Surgery /procedure Date

_____
_____
_____
_____
_____

Medications & Allergies

Please list all medications you are currently taking (include vitamins, over the counter & alternative medicines)

Medicine	Dosage	Frequency	Medicine	Dosage	Frequency

Please list any medication that you have an adverse or allergic reactions to and list the reason

Medication	Reaction	Medication	Reaction

Lifestyle

Please supply the following information regarding your lifestyle & habits.

Smoking:

Do you currently smoke? Yes __ No __ Have you ever smoked? Yes __ No __ How Many Years? ___
Type: Cigarettes __ Cigars __ Pipe __ Packs per day: _____ What year did you quit? _____

Alcohol Consumption:

Do you currently drink alcohol? Yes __ No __ Did you drink alcohol in the past? Yes __ No __
Number of servings per day: Beer _____ Wine _____ Liquor _____
If you quit drinking alcohol, when did you quit? _____ When was your last drink? _____

Caffeine Use:

Do you consume caffeine? How many servings per day? _____Type _____

Exercise:

Do you exercise regularly? Yes __ No __ What type of exercise do you do?_____ How many minutes per day do you exercise? _____ How many days per week? _____

Marital Status:

Married ___ Single ___ Divorced ___ Widowed ____ Do you own any pets? Yes __ No __

Home:

House ___ Condominium ___ Apartment ___ Assisted Living Facility ___ Skilled Living Facility ___

Family History

Please supply the following information about your immediate family. (Mother, Father, Siblings, Children)

Disorder	Yes	No	Who	Disorder	Yes	No	Who
Heart Disease	___	___	_____	High Cholesterol	___	___	_____
Hypertension	___	___	_____	Gout	___	___	_____
Heart Attack	___	___	_____	Lupus	___	___	_____
Aneurysm	___	___	_____	Bleeding Disorder	___	___	_____
Diabetes	___	___	_____	Alcohol /Drug Abuse	___	___	_____
Cancer (type)	___	___	_____	Alzheimer's Disease	___	___	_____
Stroke	___	___	_____	Psychiatric Disorder	___	___	_____
Osteoporosis	___	___	_____	Seizure	___	___	_____
Blood Clot	___	___	_____	Thyroid Disorder	___	___	_____
Tuberculosis	___	___	_____	Kidney Stones	___	___	_____
Asthma	___	___	_____	Crohn's/Ulcerative Colitis	___	___	_____

Relationship	Alive (age)	Deceased (age)	Other Medical Issues
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings			
Brother/Sister	_____	_____	_____
Brother/Sister	_____	_____	_____
Brother/Sister	_____	_____	_____
Children			
Son/Daughter	_____	_____	_____
Son/Daughter	_____	_____	_____
Son/Daughter	_____	_____	_____

Please list other doctors (specialists) you currently use:

Doctor's Name	Specialty
_____	_____
_____	_____
_____	_____