Integrated Health Care

Patient Information

First: M.I.: Last: Date:

Address:

DOB: / / Age: Sex: M F Marital Status: S M D W

Height: Weight:

Indicate Primary Phone Number
□Home # ( ) □Work # ( ) □Cell # ( )

Email: Spouse's Name:

Employer: Occupation:

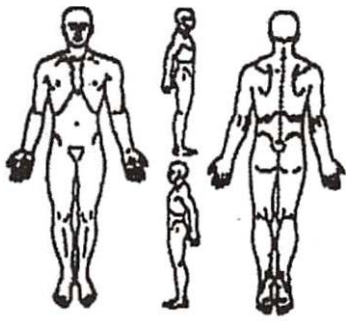
Name of Health Insurance:	Insured Name:	DOB:
Relationship to Insured:		
Is this your only form of health insurance?	YES	NO
List any other health insurances:		

How were you referred to our office? (Please Circle)

Yelp Insurance Book/Website Friend/Previous Patient Google Attorney Other:_____

Is your complaint(s) today a result of an accident of any kind?		YES	NO
Is this illness/injury under a Worker's Comp claim?		YES	NO
Is this illness/injury under an automobile accident claim?		YES (if YES please answer below)	NO
Auto Insurance Co.	Claim #	Third Party? YES	NO
Adjuster's Name	Phone #	Date of Accident	

A: Please mark the exact location of pain.



B: Please circle your symptom(s) of concern

Fatigue	Headache	Blurred Vision
Tension	Migraine	Weak Muscles
Sleeplessness	Fever	Shoulder Pain
Nausea	Chest Pain	Elbow Pain
Swelling	Sore Throat	Wrist Pain
Stiffness	Diarrhea	Hand Pain
Dizziness	Earache	Knee Pain
Numbness	Tingling	Ankle Pain
Neck Pain	Back Pain	Foot Pain

C: List your Major Complaint(s) today:

D: Please describe, in your own words, what caused your condition(s) and/or when it started:

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History Form

Name: DOB: SS#: Date:

PAST MEDICAL HISTORY

Hospitalizations	Year	Surgery/Illness	Hospital Address
1st			
2nd			
3rd			
4th			

ADDITIONAL MAJOR ILLNESS: (Please circle any that are applicable)
Liver, Thyroid, Kidney Diseases, Pancreatitis, Coronary Artery Disease, Rheumatic Fever, Bronchitis, Asthma, COPD, Emphysema, Alcohol or Drug Addiction, Hemorrhoids, Inflammatory Bowel Disease, Anxiety, Venereal Disease, Tuberculosis, Cancer, etc.

1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

TESTS: (please indicate the date when the following tests were performed: month and year)
1. Mammogram _____ 2. Flu Shot _____ 3. Pelvic/Pap _____ 4. MRI _____
5. Sigmoidoscopy _____ 6. Rectal _____ 7. EKG _____ 8. NCV _____

SOCIAL HISTORY: Lives alone or with _____

☐ Smoke ___ pack/day for ____ years ☐ None

☐ Drugs: Marijuana Cocaine, Opiates, LSD, Other ☐ None

☐ Alcoholic Beverage _____ glasses/week Beer _____/week ☐ None

FAMILY HISTORY:
Please indicate illnesses listed above for each family member including age at start of heart disease and type of cancer. If deceased, indicate age and cause of death.

Father
Mother
Sister 1
Sister 2
Brother 1
Brother 2
Other

MEDICATION: (please list any medications you are currently taking)

1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

ALLERGIES ☐ None

Medicines	Type of Reaction
1.	
2.	
3.	
4.	

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