SoutheastHEALTH

PATIENT INFORMATION FORM

Patient Name: ______________________________
Date of Birth: ______________________________

Previous and/or Maiden Name: ______________________________
Parent/Legal Guardian Name (if patient is minor): ______________________________
Patient Birth date: (M/D/Yr)______________________**Patient Gender** (Birth): [ ] Male [ ] Female
Patient SSN:______________________**Parent/ Legal Guardian SSN** (if patient is minor): ______________________
Address:______________________________ **City:**______________________ **State:**________**Zip**: __________

Home Phone:______________________**Cell Phone:**______________________**Work Phone:** ______________________
[ ] I consent for staff to leave voice mail(s) pertaining to my health information.
Email: ____________________________
I would like to receive appointment reminders (Check all that apply): [ ] Phone Call [ ] Text [ ] Email

Marital Status: ___ Single ___Married
Language: ___ English ___ Spanish ___ Other: ______________________
Race: ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ Caucasian ___ Hispanic ___ Middle Eastern ___ Multiracial ___ Native Hawaiian or other Pacific Islander ___ Other Race ___ Unknown
Ethnicity: ___ American Indian ___ Asian ___ Black or African American ___ Caucasian ___ Hispanic ___ Other ___ Unknown

EMPLOYMENT / INSURANCE

Primary Insurance Company: ______________________________
Policy Holder Name:______________________Policy Holder Relation to Patient:______________________
Policy Holder DOB:______________________Policy Holder SSN: ______________________
Policy Holder Employer:______________________Policy Holder Occupation: ______________________

Secondary Insurance Company:
Policy Holder Name:______________________Policy Holder Relation to Patient:______________________
Policy Holder DOB:______________________Policy Holder SSN: ______________________

Emergency Contact(s :

Name/Relationship / DOB:______________________________Phone Number: ______________________

Name/Relationship / DOB:______________________________Phone Number: ______________________

Name/ Relationship / DOB:______________________________Phone Number: ______________________

Power of Attorney: ______________________________

Do you have an Advanced Directive? (End of Life Care) ___ Yes ___ No

______________________________ ______________________________
Signature of patient or parent/guardian Date

Medical Record #: ______________
FOR OFFICE USE ONLY

NEW PATIENT HISTORY FORM

Patient Name: ______________________
Date of Birth: ______________________

Reason for Visit: ______________________

Primary Care Physician: ______________________

Referring Physician: ______________________

Any religious, cultural or spiritual beliefs that may affect your treatment? ☐ Yes ☐ No

If yes, please explain: ______________________

PAST MEDICAL HISTORY (Please check all that

☐ apply) Allergies
☐ Anemia
☐ Angina
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Benign Prostatic Hypertrophy
☐ Blood Clots
☐ Cancer, type: ______________
☐ CVA (stroke)
☐ COPD
☐ Coronary Artery Disease
☐ Crohn's Disease
☐ Depression
☐ Diabetes
☐ Gallbladder Disease
☐ GERD
☐ Hepatitis C
☐ HIV
☐ Hypertension
☐ Irritable Bowel Disease
☐ Liver Disease
☐ Migraine Headaches
☐ Myocardial Infarction
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Renal Disease
☐ Seizure Disorder
☐ Thyroid Disease
☐ Valve Disease
☐ Other: ______________________

PAST SURGICAL HISTORY (Please check all that apply)

☐ Angioplasty
☐ Angioplasty with Stent
☐ Appendectomy
☐ Arthroscopy Knee
☐ Back Surgery
☐ CABG (Heart Bypass
☐ Carpal Tunnel Release
☐ Cataract Extraction
☐ Cholecystectomy (Gall Bladder)
☐ Colectomy
☐ Colostomy
☐ Ear Tubes
☐ Gastric Bypass
☐ Hernia Repair
☐ Hip Replacement
☐ Knee Replacement
☐ Lasik
☐ Liver Biopsy
☐ Open Reduction Internal Fixation
☐ Pacemaker
☐ Small Bowel Resection
☐ Thyroidectomy
☐ Tonsillectomy

☐ Other: ______________________

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NEW PATIENT HISTORY FORM

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SOCIAL HISTORY

Been exposed to Hazardous Materials (example: asbestos, radiation, TB, tec.): __ Yes __ No

Special Diet Restrictions: ____

Frequency of Exercise: [ ] None/Occasionally [ ] 1-2 times/week [ ] 3-5 times/week [ ] Everyday

Type of Exercise (ex: aerobic, walking, martial arts, etc.): ____

Drug Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit:________________

Type of Drug(s) (ex: acid, cocaine, marijuana, etc.): ____

Route of Drug(s) (ex: , inhale, in muscle, oral, etc.):____

Alcohol Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit:________________

Alcohol Type:______________________ Drinks Per Week:____________________ Years Used: _______________

Tobacco Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit: _______________

Type:________________________________Packs/Cans Per Day:_________________Years Used: ______________

Exposed to second hand smoke: [ ] Yes [ ] No

SoutheastHEALTH

Medical Record #: ____________

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NEW PATIENT HISTORY FORM

Patient Name: ____________________

Patient DOB: ____________________

FAMILY HISTORY (Please check all that apply)

	Condition											
__	ADD/ ADHD	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Alcoholism	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Allergies	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Alzheimer's Disease	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Asthma	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Blood Disease	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Breast Cancer	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Colon Cancer	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	CVA (stroke)	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Depression	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Developmental Delay	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Diabetes	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Eczema	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Hearing Deficiency	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Heart Disease	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	High Blood Pressure	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Hyperlipidemia	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Irritable Bowel Disease (IBS)	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Learning Disability	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Lung Cancer	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Mental Illness	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Migraines	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Obesity	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Osteoarthritis	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Prostate Cancer	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	PVD (Blood flow problems in arms, legs, or neck)	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Renal Disease	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Seizure Disorder	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______
__	Thyroid Disease	__	Mother	__	Father	__	Brother	__	Sister	__	Other	______

Other: ____

SoutheastHEALTH

Medical Record #: ____________________

FOR OFFICE USE ONLY

MEDICATION & ALLERGIES FORM

Patient Name: ______________________________

Date of Birth: ______________________________

PHARMACY INFORMATION

Pharmacy Name: ____

Location: ____

ALLERGIES

☐ None ☐ Penicillin ☐ Sulfa Drugs ☐ IVP Dye

☐ Food: ____

☐ Other: ____

MEDICATIONS

NAME	DOSAGE	HOW OFTEN?

Medical Record #: ____________________

FOR OFFICE USE ONLY

CURRENT CONDITIONS FORM
ORTHOPEDIC CLINIC

Patient Name: ____________________________

Date of Birth: ____________________________

Please check all that apply

General:
- ☐ Weight Change > 10lbs
- ☐ Fever
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Blood Transfusion

Head & Neck:
- ☐ Visual Changes
- ☐ Dizziness
- ☐ Double Vision
- ☐ Sinus Problems
- ☐ Frequent Nosebleeds
- ☐ Ear Pain
- ☐ Trouble Hearing
- ☐ Ringing in Ears
- ☐ Hoarseness
- ☐ Persistent Sore Throat
- ☐ Mouth Sores
- ☐ Swollen Glands

Respiratory/Lungs:
- ☐ Stop Breathing During Sleep
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Cough
- ☐ Sore Throat

Reproduction:
- ☐ Blood in semen (men)
- ☐ Inability to Have Erection
- ☐ Inability to Reach Climax
- ☐ Infertility
- ☐ Painful Intercourse
- ☐ Decreased Sexual Desire
- ☐ Sexually Transmitted Disease

Women:
- ☐ Breast Pain/Lumps
- ☐ Pelvic Pain
- ☐ Vaginal Discharge
- ☐ Frequent Sweats/Hot Flashes
- ☐ Menstrual Problems
- ☐ Menopause
- ☐ Pregnancy Problems
- ☐ Baby Weighing 9lbs or More

Skeletal:
- ☐ Gout
- ☐ Back Pain (Major)
- ☐ Neck Pain (Major)
- ☐ Weakness of Arm / Leg
- ☐ Joints Swelling/ Stiffness
- ☐ Deformities of Back/ Extremities

Heart/Vascular:
- ☐ Chest Pain/Tightness
- ☐ Irregular Rapid Heart Beat
- ☐ Smothering Feeling at Night
- ☐ Ankle Swelling

Stomach/Bowel:
- ☐ Black/Bloody Stool
- ☐ Nausea/Vomiting (Frequent)
- ☐ Frequent Heart Burn/ Acid (GERD)
- ☐ Abdominal Pain
- ☐ Diarrhea (Frequent)
- ☐ Constipation
- ☐ Difficulty Swallowing
- ☐ Vomiting Blood

Kidney/Bladder:
- ☐ UTI
- ☐ Urinary Incontinence
- ☐ Urinary Hesitancy
- ☐ Frequent Urination
- ☐ Urinary Urgency
- ☐ Nocturia
- ☐ Dysuria
- ☐ Hematuria
- ☐ Urinary Retention

Neuro:
- ☐ Numbness/Tingling
- ☐ Severe Frequent Headaches
- ☐ Abnormal Coordination
- ☐ Trouble with Speech
- ☐ Forgetfulness/ Confusion

Skin & Hair Problems:
- ☐ Changes in Hair/ Hair Loss
- ☐ Major Skin Problems
- ☐ Wounds Not Healing
- ☐ Persistent Rash
- ☐ Changes in Moles

Psych/Social:
- ☐ Feeling Blue/ Discouraged
- ☐ High Anxiety/Stress
- ☐ Loss of Friends
- ☐ Feeling Life Has No Purpose
- ☐ Feeling Others Are Talking About You
- ☐ Feeling Fear
- ☐ Hearing Voices
- ☐ Marital or Relationship Problems
- ☐ Early Morning Awakenings

☐ I have reviewed the review of systems for this patient.

Provider Signature: ______________________________

PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Printed Name	Date of Birth	Med. Record Number

To our valued patients:

While coordinating care during your treatment at Southeast Health, our healthcare professionals may be asked to discuss your health information with a family member or friend involved in your care (i.e., to make arrangements for physician appointments, discuss diet, care, or medication instructions, discuss information related to any of your medical/health−related conditions, answer financial/billing questions, etc.).

You may also find it neccessary to have a family member or friend pick up your prescription that can't be called in or e−prescribed.

We ask that provide the names and relationships of family member(s) and friend(s) who you authorize to have access to your health information and/or pick up prescriptions during your treatment at Southeast Health.

Permission to Discuss PHI and Release Prescriptions:

Name	Relationship to Patient	Please check box if permitted to pick up your prescriptions:
		❑
		❑
		❑
		❑
		❑

PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION CONT.

Patient Printed Name	Date of Birth	Med. Record Number

Additional Disclosure Permissions:

If this patient has a legal representative or Durable Power of Attorney for Healthcare, please note here and provide a copy of the legal documentation for filing with the patient's electronic medical record:

Name of Rep or DPOA	Type of Representative	Phone Number

I further understand that this authorization will remain in effect until and/or may be revoked at any time by myself, my legal representative, or my Durable Power of Attorney for Healthcare.

Patient Signature	Date	Time

Witness Printed Name	Relationship or Title

Witness Signature	Date	Time

Thank you. Southeast Health respects your right to privacy.