



Medical Record #: _____

FOR OFFICE USE ONLY

PATIENT INFORMATION FORM

Patient Name: _____

Date of Birth: _____

Previous and/or Maiden Name: _____

Parent/Guardian Name if patient is minor: _____

Birth date: (M/D/Yr) _____ Gender: Male Female

SSN (patient): _____ SSN (guardian, if patient is minor): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Marital Status: Single Married Widowed Divorced

Spouse's Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____

Spouse's Employer: _____ Phone Number: _____

Language: English Spanish Other: _____

Race: Caucasian or White Black or African American American Indian Alaska Native Asian
 Native Hawaiian Pacific Islander Other: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino

EMPLOYMENT

Patient/Parent's Employer: _____ Phone Number: _____

Occupation: _____

Been Exposed to Hazardous Materials (ex: asbestos, radiation, TB, etc.): Yes No

INSURANCE

Primary Insurance Company: _____

Plan #: _____ Policy Holder: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Secondary Insurance Company: _____

Plan #: _____ Policy Holder: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Emergency Contact - Individuals with whom we may discuss medical care/authorization for treatment:

Name/Relationship: _____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

Power of Attorney: _____

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

How did you hear about us? TV/Radio Newspaper Community Friend/Relative
 Social Media Mailer Other

Signature of patient or guardian

Date



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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):

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> COPD | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Benign Prostatic Hypertrophy | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer (type) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Valve Disease |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Irritable Bowel Disease | |
| <input type="checkbox"/> Other: _____ | | |

PAST SURGICAL HISTORY (Please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cholecystectomy (Gall Bladder) | <input type="checkbox"/> Lasik |
| <input type="checkbox"/> Angioplasty with Stent | <input type="checkbox"/> Colectomy | <input type="checkbox"/> Liver Biopsy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Open Reduction & Internal Fixation |
| <input type="checkbox"/> Arthroscopy Knee | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Small Bowel Resection |
| <input type="checkbox"/> CABG (Heart Bypass) | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Knee Replacement | |
| <input type="checkbox"/> Other: _____ | | |



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NEW PATIENT HISTORY FORM

Patient Name: _____

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SOCIAL HISTORY

Special Diet Restrictions: _____

Frequency of Exercise: None/Occasionally 1-2 times/week 3-5 times/week Every day

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



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NEW PATIENT HISTORY FORM

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FAMILY HISTORY (Please check all that apply):

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Depression	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Eczema	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hearing Deficiency	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Irritable Bowel Disease (IBS)	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Migraines	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Obesity	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> PVD (Blood flow problems: arms, legs, neck)	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Other	_____

Other: _____



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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 taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



**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

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