HISTORY AND PHYSICAL

Name ______ Date ______

______

______ Birth Date ______

DRUG ALLERGIES

______

CURRENT MEDS

______

FAMILY HISTORY

	Father	Mother	Mother's Parents	Father's Parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

PAST MEDICAL HISTORY

☐ Tetanus ______
☐ Diphtheria ______
☐ Polio ______
☐ Rubella ______
☐ Measles ______
☐ Pneumonia ______
☐ Mumps ______
☐ Rheumatic fever ______
☐ Venereal disease ______
☐ Bronchitis ______
☐ Hepatitis ______
☐ Anemia ______
☐ Scarlet fever ______

☐ Allergies/Hay fever ______
☐ Asthma ______
☐ Chronic rashes ______
☐ Ulcer ______
☐ GI disorder ______
☐ Gall bladder disease ______
☐ Prostate disease ______
☐ Bowel irregularity ______
☐ Sexual/Menstrual dysfunction ______
☐ Arthritis ______
☐ Nervousness ______
☐ Depression ______
☐ Gout ______

☐ Frequent infections ______
☐ Shortness of breath ______
☐ Heart palpitations ______
☐ Heart murmur ______
☐ Heart Disease/Attack ______
☐ Dizziness/Fainting ______
☐ Peripheral vascular disease ______
☐ High blood pressure ______
☐ Diabetes ______
☐ Seizure/Epilepsy ______
☐ HIV positive ______
☐ AIDS ______
☐ Other ______

HABITS

☐ Smoke: Packs daily ______ How long ______ When stopped ______
☐ Exercise routine ______ ☐ Coffee: Cups daily ______ Other caffeines ______
☐ Alcohol: Type/Amount ______ ☐ Sleep pattern ______
☐ Diet: Salt ______ ☐ Cholesterol ______

PATIENT INFORMATION FORM

PATIENT NAME: ______________ LAST ______________ FIRST ______________ MIDDLE

DATE: ______________
SEX: ______________
DATE OF BIRTH: ______________
MARITAL STATUS: ______________

CHILD: ☐

ADULT: ☐

SS#: ______________ REFFERRED BY: ______________

ADDRESS: ______________ STREET

______________ CITY ______________ STATE ______________ ZIP

TELEPHONE NUMBER: HOME: ______________ WORK: ______________

NEAREST RELATIVE NOT LIVING WITH PATIENT: ______________ PHONE: ______________

GUARANTOR: ______________

EMPLOYER: ______________ OCCUPATION: ______________

ADDRESS: ______________ STREET

______________ CITY ______________ STATE ______________ ZIP

PRIMARY MEDICAL INSURANCE COVERAGE: (ALL BLANKS MUST BE FILLED IN)

INSURANCE COMPANY: ______________

CLAIMS ADDRESS: ______________

CLAIMS ADDRESS: ______________

TELEPHONE #: ______________

NAME OF INSURED: ______________

SS# OF INSURED: ______________ GROUP#: ______________

DO YOU HAVE SECONDARY COVERAGE: YES/NO

NAME OF SECONDARY MEDICAL INSURANCE: ______________

NAME OF INSURED: ______________

SS# OF INSURED: ______________

EFFECTIVE DATE: ______________ PPO/HMO NETWORK: ______________

INS. VERIFIED BY: ______________ DATE: ______________

EFFECTIVE DATE: ______________ NAME OF INSURED:

PPO/HMO NETWORK: ______________ PRIMARY CARE PHYSICIAN: ______________

CO-PAY AMOUNT: ______________ CALENDAR YEAR DEDUCTIBLE: ______________

RELEASE OF MEDICAL INFORMATION/ELIGIBILITY GUARANTEE FORM

I, ______________________________, hereby certify that I am eligible for health plan coverage as indicated on my information form. I understand that if a primary care physician is required by my plan that it is my responsibility to notify the insurance company prior to receiving services. If any of the above information is not true or if I am not eligible under the terms of my coverage, I understand that I am liable for all approved charges for services rendered.

I authorize the release of any medical or other information necessary to process my insurance claims.

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for noncovered services. I also authorize the physician to release any information to process this claim.

SIGNED: ______________________________ DATE: __________

MED-RLSE.DOC