CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be glad to have our Patient Services Representative help you.

Your Name: ____ Date: __________________

Address: ______________________________________ Apt or Space #: ________________________

City: ____ State: __________ Zip: ____________

Home Phone #: (____) ___________________ Work Phone #: (____)_______________

Cell Phone#: (   )____________________ E-Mail: ____________________________________

Date of Birth: _____/_______/ _________ Social Security #: ___________- ________-___________

Occupation: ____________________________ Employer:_________________________________

Work Address: ____

City:____ State: __________ Zip: _____________

Is your visit due to an accident/injury: ☐ Yes ☐ No If yes, date of injury.________ County_____________

Are you a Medicare Patient: ☐ Yes / ☐ No Medicare #: ___________________________

Your Spouses Name: _________________________________ Spouses work # (____)__________________

Name of person to contact in case of emergency: ____

Their home and work numbers (____)_______________________ (____)_____________________________

Who referred you to this office: ___________________________ How else have you heard of us__________

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT ANY CHARGES INCURRED BY ME IN THIS OFFICE ARE MY SOLE REPONSIBILITY, DESPITE ANY INSURANCE PLAN, LEGAL INVOLVEMENT, OR SETTLEMENT.

PATIENT'S SIGNATURE: ____ DATE ______/_____/______

PARENT OR GUARDIAN:____

SIGNATURE: ____ DATE ______/______/______

PATIENT NAME: ____________________________ PATIENT #:_____________ DATE:______/_____/_________

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INSURANCE COVERAGE INFORMATION PAGE 2

HEALTH INSURANCE:

Primary Insurance Carrier: ____ Phone #: (____) ______________

Policy Holder Name: ______________________________________ Policy Holders DOB: _____/_____/_____

Policy #: __________________________Group#:____

Secondary Insurance Carrier:_____________________________________ Phone # (____)________________

Policy #___________________________ Group # ____

WORKERS COMPENSATION INJURY:

Employer:_____________________________________ Work #: (______)______________________________

Address: __________________________________ City: _____________ State:__________ Zip:____________

Was injury/accident reported to supervisor Y / N Date:_________________ Time:______________________

Employers Ins. Carrier: ____ Policy: _______________________

Carriers Phone#: (____) ________________Adjuster:__________________ Claim #____________________

AUTO/PERSONAL INJURY

Do you have "Med Pay" on your Auto Policy: Yes / No Amount $___________________________

Insurance Carrier Name: ____ Phone: _____________________

Adjuster: ____ Claim Number: ________________________

Attorney Name (if applicable): _____________________________Phone # (_____) _____________________

THIRD PARTY PAYER (OTHER INVOLVED INSURANCE)

Third Party (person(s) at fault's) Name: ______________________________Phone#: (___) _____________

Their Insurance Carrier: ____ Phone #: (___)_______________

Address: ____ City: _______________________ State: _______

Zip:________ Adjuster: ____________________________________ Claim #:___________________

PATIENT NAME: ___________________________ PATIENT #:____________ DATE:______/_____/_________

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PRESENT COMPLAINTS

What are you being seen for today: ____

How long has this bothered you? ____

Have you seen anyone else for this problem? Y / N If yes, who: ______________________________

Relevant Medical History: (Please check the conditions that you have now or have had previously)

	Current	Past		Current	Past		Current	Past
Abdominal Pain	☐	☐	Epilepsy	☐	☐	Multiple Sclerosis	☐	☐
Acid Reflux	☐	☐	Excessive Thirst	☐	☐	Muscular Dystrophy	☐	☐
Anemia	☐	☐	Fibromyalgia	☐	☐	Neck Pain/Spasm	☐	☐
Arthritis	☐	☐	Frequent Urination	☐	☐	Neuritis	☐	☐
Asthma	☐	☐	Hand or Wrist Pain	☐	☐	Numbness	☐	☐
Back Pain	☐	☐	Headaches	☐	☐	Painful Urination	☐	☐
Breast Discharge	☐	☐	Heartburn	☐	☐	Polio	☐	☐
Breast Lumps	☐	☐	Heart Problems	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Sinus Trouble	☐	☐
Concussion	☐	☐	High Blood Pressure	☐	☐	Sciatica	☐	☐
Convulsion	☐	☐	HIV	☐	☐	TB	☐	☐
Depression	☐	☐	Hot Flashes	☐	☐	Varicose Veins	☐	☐
Diabetes	☐	☐	Kidney Stones	☐	☐	Venereal Disease	☐	☐
Difficulty Urinating	☐	☐	Measles	☐	☐	Whiplash	☐	☐
Digestion Problems	☐	☐	Menstrual Cramps	☐	☐			
Dizziness	☐	☐	Menstrual Irregularity	☐	☐			

Are you currently pregnant? ___________________________ Due Date ______________

Contraception Type: _______________________ Age at First Period: _________ Duration of Cycle: _______

Duration of Flow: ____________ # of Pregnancies: ___________ # of Births: __________

# of Miscarriages: ______________ # of Abortions: ___________ Menstrual Flow ☐ Heavy ☐ Mod ☐ Light

Last Period: ____________ Last Vaginal Exam: _____________ Last Mammogram:___________

Last Prostate Exam _________________

Date of last Tetanus booster________________

PATIENT NAME: ___________________________ PATIENT #:____________ DATE:______/_____/_________

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PRESENT COMPLAINTS

List any operations that you've had and approximate dates:

1. ________________________________ Date: ____________ Dr.:____________________________

2. ________________________________ Date: ____________ Dr.:____________________________

3. ________________________________ Date: ____________ Dr.: ____________________________

4. ________________________________ Date: ____________ Dr.:____________________________

Are you allergic to any medication? Y / N Please list: ____

____

Are you taking any medications? Y / N Please list: ____

____

____

Do you smoke? Y / N Amount per day Do you drink? Y / N ☐ Social ☐ Light ☐ Medium ☐ Heavy

Caffeine: ________ Cups/Day Exercise: ☐ Never ☐ Sometimes ☐ Frequently ☐Regularly

FAMILY HEALTH HISTORY - LIST ANY DISEASES WHICH RUN IN YOUR FAMILY

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

PATIENT NAME: ______________________________ PATIENT #:_____________ DATE:______/_____/_________

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