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Patient Information & Release Form

Name: _____
 First Middle Last
Address: _____
 Street City State Zip
Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Social Security Number: _____
Sex: _____ Single: _____ Married: _____ Divorced: _____ Widowed: _____ Pets: _____
Employer: _____ Occupation: _____
Employer's Address: _____
Referred By: _____
Spouse or closest relative: _____
His/Her phone number: _____ Relationship: _____
Person responsible for bill: _____
Person who will act as your healthcare advocate if needed:
Name: _____ Phone: _____

Do you have any Advanced Directives/Living Will: Yes _____ No _____
If so, please provide a copy for your chart.
Pharmacy name and location: _____
Do we have your permission to:
Leave a message on your answering machine at home? _____ Email? _____
Leave a message at your place of employment? _____
Discuss your medical condition with any member of your household? _____
If yes, with whom? _____ Relationship: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT : 1/1/18

The undersigned acknowledges receipt of the Notice of Privacy Practices
Required by HIPPA>

Signed by: _____
_____ Date: _____

Printed patient name

E-mail address: _____

Past Medical History

Please check if you have had any of the following conditions or have had them in the past

Cardiovascular	Pulmonary	Heme	Other
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Bronchitis/Chronic	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Alcohol/Drug Abuse
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis	Autoimmune Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Requiring Stent	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lupus	<input type="checkbox"/> Allergies
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Heart Failure	Genitourinary	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Breast Lumps
<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Urinary Tract Inf	Neuro/Mental Health	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Other Cancer
Gastrointestinal	<input type="checkbox"/> Abnormal Pap	<input type="checkbox"/> Alzheimer's Disease	
<input type="checkbox"/> Gastritis	<input type="checkbox"/> Prostate Issues	<input type="checkbox"/> Psychiatric Disorder	
<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Crohn/Colitis	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Depression	
<input type="checkbox"/> Hemorrhoids	Endocrinology	<input type="checkbox"/> Migraines	
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Osteoporosis		
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Thyroid Disorder		

Please list any other medical problems you have that are not listed above.

Past Hospitalizations

Past Surgical History

Please list any you have had in the past

Reason for Hospitalization	Reason for Surgery /procedure

Medications & Allergies

Please list all medications you are currently taking (include vitamins, over the counter & alternative medicines)

Medicine	Dosage	Frequency	Medicine	Dosage	Frequency

Please list any medication that you have an adverse or allergic reactions to and list the reason

Medication	Reaction	Medication	Reaction

Lifestyle

Please supply the following information regarding your lifestyle & habits.

Smoking:

Do you currently smoke? Yes ___ No ___ Have you ever smoked? Yes ___ No ___ How Many Years? ___
 Type: Cigarettes ___ Cigars ___ Pipe ___ Packs per day: _____ What year did you quit? _____

Alcohol Consumption:

Do you currently drink alcohol? Yes ___ No ___ Did you drink alcohol in the past? Yes ___ No ___
 How much did you drink? _____ What type of alcohol? _____
 If you quit drinking alcohol, when did you quit? _____

Caffeine Use:

Do you consume caffeine? How many servings per day? _____ Type _____

Exercise:

Do you exercise regularly? Yes ___ No ___ What type of exercise do you do? _____
 How many minutes per day do you exercise? _____ How many days per week? _____

Marital Status:

Married ___ Single ___ Divorced ___ Widowed ___ Do you own any pets? Yes ___ No ___

Home:

House ___ Condominium ___ Apartment ___ Assisted Living Facility ___ Skilled Living Facility ___

Family History

Please supply the following information about your immediate family. (Mother, Father, Siblings, Children)

Disorder	Yes	No	Who	Disorder	Yes	No	Who
Heart Disease	___	___	_____	High Cholesterol	___	___	_____
Hypertension	___	___	_____	Gout	___	___	_____
Heart Attack	___	___	_____	Lupus	___	___	_____
Aneurysm	___	___	_____	Bleeding Disorder	___	___	_____
Diabetes	___	___	_____	Alcohol/Drug Abuse	___	___	_____
Cancer (type)	___	___	_____	Alzheimer's Disease	___	___	_____
Stroke	___	___	_____	Psychiatric Disorder	___	___	_____
Osteoporosis	___	___	_____	Seizure	___	___	_____
Blood Clot	___	___	_____	Thyroid Disorder	___	___	_____
Tuberculosis	___	___	_____	Kidney Stones	___	___	_____
Asthma	___	___	_____	Crohn's/Ulcerative Colitis	___	___	_____

Relationship	Alive (age)	Deceased (age)	Other Medical Issues
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings			
Brother/Sister	_____	_____	_____
Brother/Sister	_____	_____	_____
Brother/Sister	_____	_____	_____
Children			
Son/Daughter	_____	_____	_____
Son/Daughter	_____	_____	_____
Son/Daughter	_____	_____	_____

Please list other doctors (specialists) you currently use:

Doctor's Name	Specialty
_____	_____
_____	_____
_____	_____