

# MEDICAL HISTORY (confidential)

Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

YES NO

(Women) Are you pregnant? \_\_\_\_\_   Medications? \_\_\_\_\_

Receiving any medication or drugs? \_\_\_\_\_   \_\_\_\_\_

Ever been hospitalized? \_\_\_\_\_   \_\_\_\_\_

Ever had surgery? \_\_\_\_\_   Allergies? \_\_\_\_\_

Is there excessive bleeding when cut? \_\_\_\_\_   \_\_\_\_\_

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Allergies to Drugs      | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Sinus Problems             |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemical Dependency     | Describe _____                                | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       |   |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Scarlet Fever         |   |

## AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## RELEASE AND ASSIGNMENT

I certify that I am covered by insurance with \_\_\_\_\_  
Name of Insurance Company (ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please note that we require a 24-hour notice for cancelling appointments unless in the event of an emergency. Excessive failure to comply will result in a \$25.00 charge.

Thank you .