

DIAGNOSTIC CENTER OF MEDICINE

New Patient Established Pt.

DATE	PLEASE ENTER THE NAME OF THE DOCTOR SEEING YOU TODAY	PATIENT NUMBER

PATIENT INFORMATION

PATIENT NAME (LAST)		(FIRST)		(M.I.)		SSN:	
HOME PHONE ()	SEX	DATE OF BIRTH	AGE	MARITAL STATUS	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	RACE	<input type="checkbox"/> CAUCASIAN <input type="checkbox"/> AFRICAN-AMERICAN
						<input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER	
ADDRESS						APT. / SPACE / UNIT #	
CITY				STATE		ZIP	
PATIENT'S EMPLOYER (Guarantor if patient is a minor or unemployed)				OCCUPATION			
EMPLOYER'S ADDRESS						WORK PHONE ()	
CITY				STATE		ZIP	

GUARANTOR INFORMATION

GUARANTOR NAME (LAST)		(FIRST)		(M.I.)		SSN		HOME PHONE ()	
GUARANTOR ADDRESS				CITY		STATE		ZIP	
GUARANTOR EMPLOYER				OCCUPATION				WORK PHONE ()	
GUARANTOR EMPLOYER ADDRESS				CITY		STATE		ZIP	

M.D.	REASON FOR VISIT	REFERRING PHYSICIAN	HOW DID YOU HEAR ABOUT OUR OFFICE?
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EMERGENCY	WHO TO NOTIFY IN CASE OF AN EMERGENCY	PHONE ()	RELATIONSHIP	
	ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION (Please have receptionist copy your insurance cards)

1.	PRIMARY INSURANCE CO.		PHONE ()	
	ADDRESS	CITY	STATE	ZIP
	POLICY HOLDER NAME	DATE OF BIRTH		SSN
	RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER		
	POLICY #	GROUP #	EFFECTIVE DATE	

2.	SECONDARY INSURANCE CO.		PHONE ()	
	ADDRESS	CITY	STATE	ZIP
	POLICY HOLDER NAME	DATE OF BIRTH		SSN
	RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER		
	POLICY #	GROUP #	EFFECTIVE DATE	

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor.

A copy of the signature is as valid as the original.

PATIENT SIGNATURE	DATE	GUARANTOR SIGNATURE	DATE	REGISTERED BY INITIALS
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Diagnostic Center of Medicine

CONFIDENTIAL MEDICAL HISTORY

Patient Name: _____

Record #: _____

Name: _____ Age: _____ Date: _____

Referred by (if any) _____

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space. Please leave no blanks.

GENERAL HEALTH AND HABITS

Characterize your present health status: Excellent () Very Good () Average () Poor ()

Exercise

Do you exercise regularly? Yes () No ()
How long have you exercised on a regular basis? yrs.
Type of exercise(s)
How often days/weeks minutes each time

Smoking

Do you smoke? Yes () No ()
How many per day For how many years
What do you smoke? Cigarettes () Pipe ()
Cigars () Other (specify)
When did you quit smoking? years ago
How long have (had) you smoked? years

Nutrition

Your weight: 10 years ago 5 years ago now
Your appetite: Excellent () Good () Fair () Poor ()
Are there foods you avoid (or limit) for health reasons?
Specify:

Alcohol/Beverage

Estimate the amount of alcohol you drink regularly:
..... drinks* per day drinks per week
Did you formerly drink alcohol but have permanently stopped?
Yes () No ()

Estimate the amount of caffeinated beverages (coffee, tea, cola) you drink per day glasses, cups, or cans

* one drink = 1 can beer, 4 oz. wine or 1 oz. hard liquor

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgery you have had, indicating the nature of each operation and where and when it was done. (Be accurate and complete. Consult family, friends, physicians, etc.)

Operation	Hospital and City	Date

Have you ever been seriously injured? (If so, give details and date) _____

List chronologically all hospitalizations not already mentioned. (Do not include childbirth.)

Reason for Hospitalization	Hospital and City	Date

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

	NO	YES ? DATE OF ONSET		NO	YES ? DATE OF ONSET	
URINARY			PHYSICIAN'S COMMENT (leave Blank)			
Have you ever had or been told you had any of the following? (If so, indicate when.)				NEUROLOGICAL		
Kidney disease or nephritis				Have you ever had any of the following? (If so, indicate when.)		
Protein or albumin in urine				Neurological disease		
Blood or pus in urine				Frequent or recurrent headaches		
Kidney stones				Loss of consciousness		
Urinary infection				Convulsions or seizures		
Prostate trouble				Head injury		
Syphilis or gonorrhea				Stroke		
How many times do you urinate: at night? _____				Paralysis or muscular weakness		
during the day _____				Tremor or abnormal movements		
Do you have discomfort passing urine?				Difficulty with coordination		
Have you ever had a kidney x-ray (I.V.P.)				Difficulty in walking		
				Difficulty in speaking		
				Double vision or loss of vision		
			Numbness			
			Difficulty with memory			
			Dizziness			
OBSTETRIC & GYNECOLOGICAL			MOOD			
Have you ever had tumor(s), cyst(s), or other breast disease?			Have you recently...			
How many times have you been pregnant? (including miscarriages)?			Experienced severe anxiety, panic or phobias?			
How many live births? _____			Found it hard to concentrate?			
Do you ever bleed ("spot") between periods or after intercourse?			Felt unable to enjoy your usual activities?			
At what age did you begin to menstruate? _____			Had a weight change or eating disorder?			
Have you ever had toxemia?			Had insomnia or excessive daytime sleepiness?			
Have you ever had a hysterectomy?			Thought yourself undeserving or worthless?			
Are you now taking hormones or birth control pills?			Felt excessively fatigued?			
When was your last Pap smear? _____			Felt depressed?			
Have you had an abnormal Pap smear?			Have you ever:			
If you are still menstruating: Your last period? _____			Had a nervous breakdown or psychiatric care?			
The one before? _____			Had a drug or alcohol problem?			
How many days do your periods usually last? _____			Would you like consultation with a mental health professional?			
Are your periods regular?						
How heavy are they? _____			SPECIAL SENSES			
What is your cycle length? _____			Have you ever had:			
If you had your change of life: When was your last period? _____			Glaucoma			
Have you bled since?			Other major eye disease			
			Deafness			
			Abnormal noises in the ear			
SEXUAL			ALLERGY & IMMUNOLOGY			
Are you having sexual difficulties?			Have you ever had			
			Asthma?			
			Eczema or other skin problems?			
			Hay fever or stuffy nose/sinuses?			
			A reaction to penicillin?			
			A reaction to aspirin?			
			A reaction to any other drug?			
			(Specify)			
HEMATOLOGY & ONCOLOGY			Date last immunized for	YEAR		
Have you ever had			Tetanus-Diphtheria (every 5-10 yrs.)			
Anemia?			Pneumococcal Pneumonia (Pneumovax)			
Bleeding or bruising tendency?			Influenza (annual - Fall)			
Cancer or tumor?						
X-ray or radiation treatment						

CURRENT MEDICATIONS

List all the medications you are NOW taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list MUST be detailed, accurate, and complete; therefore consult with your family, druggist, physician. (Do not neglect aspirin and pain medicines; hormones; contraceptives, water, diet, nerve or sleeping pills.)

Name of medicine	Strength of each dose	How often taken	When began taking

PERSONAL HISTORY

Where were you born? _____

Have you ever lived or traveled extensively abroad?
(If so, give details) _____

What is your occupation? _____

Do you enjoy your work(retirement)? _____

Have you ever worked in the field of medicine
in any capacity (including volunteer, aide, clerk,
technician)? _____

What is the highest level of education you
have attained? _____

What inhaled chemicals or particles are you exposed to at your place of
work? _____

List the areas you have lived in chronologically, giving dates:

Area	From	To

List your past occupations chronologically, giving dates:

Occupation	From	To

FAMILY HEALTH

Please give the following information about the health of your immediate family:

RELATION	Age if alive	Age at death	State of health or cause of death
Mother			
Father			
Brothers and Sisters			
Spouse			
Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)

Diabetes _____ Cancer (specify type if known) _____
Migraine _____ Seizures or epilepsy _____ Any obscure or unusual disease _____
Allergies _____ Blood disease _____ Abnormal bleeding or clotting _____
Alcoholism _____ Psychiatric disease or suicide _____ A disease which "runs in the family" _____
"Heart Attack" _____ High blood pressure _____ Kidney disease _____

Signature of Patient _____