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 ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED	RACE ☐ CAUCASIAN ☐ AFRICAN-AMERICAN ☐ HISPANIC ☐ ASIAN ☐ 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?

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 _____

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/week 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 caffinated beverages ALL 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
RESPIRATORY		
Have you ever had any of the following? (If so, indicate when)		
Pneumonia		
Severe bronchitis		
Pleurisy		
Tuberculosis skin test (Pos or Neg)		
Tuberculosis (infection or contact)		
Asthma (wheezing)		
Chronic bronchitis		
Emphysema		
Other lung trouble		
Exposure to dangerous dust or fumes		
Trouble breathing		
Excessive snoring		
Do you have chest pain?		
Abnormal chest x-ray?		
Have you ever coughed up blood?		
Do you often or regularly		
Cough?		
Raise sputum?		
Do you often get chest colds?		
When was your last chest x-ray?		
CIRCULATORY		
Have you ever had any of the following? (If so, indicate when.)		
Chest pain		
Heart trouble		
Heart attack (coronary)		
Angina pectoris		
High cholesterol		
High blood pressure		
Blackouts		
Racing of heart		
Rheumatic fever		
Heart failure		
Abnormal electrocardiogram		
Swelling of your ankles		
Have you ever taken heart or water pills?		
ENDOCRINOLOGY		
Have you ever had any of the following? (If so, indicate when.)		
Hormone problems		
Thyroid disease		
Diabetes		
Osteoporosis		

PHYSICIAN'S COMMENT
(leave Blank)

	NO	YES ? DATE OF ONSET
DIGESTIVE		
Do you often or regularly have		
Poor appetite		
Trouble swallowing		
"Heartburn"		
Regurgitation of food or bile		
Nausea or vomiting		
Abdominal pain		
Constipation		
Diarrhea		
Has there been any change in your bowel function in the last 6 mos.?		
Have you ever had any of the following? (If so, indicate when.)		
Hiatal or esophageal hernia		
Duodenal or gastric ulcer		
Vomiting of blood		
Black or tarry stools		
Blood in your stool		
Yellow jaundice		
Liver trouble or hepatitis		
Gallbladder trouble or stones		
Persistent diarrhea or colitis		
Diverticulitis		
Parasitis infection.		
Hernia		
Other digestive disease		
When was your last:		
Upper GI x-ray		
Barium enema x-ray		
Gallbladder x-ray/ultrasound		
UGI endoscopy (gastroscopy)		
Colonoscopy		
JOINTS		
Have you ever had any of the following? (If so, indicate when.)		
Muscle pain		
Back pain		
Joint pain		
Joint swelling		
Gout		
Has your doctor diagnosed arthritis, rheumatism?		
CUTANEOUS		
Have you ever had		
skin rashes		
skin cancer		

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
URINARY		
Have you ever had or been told you had any of the following? (If so, indicate when.)		
Kidney disease or nephritis		
Protein or albumin in urine		
Blood or pus in urine		
Kidney stones		
Urinary infection		
Prostate trouble		
Syphilis or gonorrhea		
How many times do you urinate: at night? _____ during the day _____		
Do you have discomfort passing urine?		
Have you ever had a kidney x-ray (I.V.P.)		
OBSTETRIC & GYNECOLOGICAL		
Have you ever had tumor(s), cyst(s), or other breast disease?		
How many times have you been pregnant? (including miscarriages)? _____ How many live births? _____		
Do you ever bleed ("spot") between periods or after intercourse?		
At what age did you begin to menstruate? _____		
Have you ever had toxemia?		
Have you ever had a hysterectomy?		
Are you now taking hormones or birth control pills?		
When was your last Pap smear? _____		
Have you had an abnormal Pap smear?		
If you are still menstruating: Your last period? _____ The one before? _____		
How many days do your periods usually last? _____		
Are your periods regular?		
How heavy are they? _____ What is your cycle length? _____		
If you had your change of life: When was your last period? _____		
Have you bled since?		
SEXUAL		
Are you having sexual difficulties?		
HEMATOLOGY & ONCOLOGY		
Have you ever had		
Anemia?		
Bleeding or bruising tendency?		
Cancer or tumor?		
X-ray or radiation treatment		

PHYSICIAN'S COMMENT
(leave Blank)

	NO	YES ? DATE OF ONSET
NEUROLOGICAL		
Have you ever had any of the following? (If so, indicate when.)		
Neurological disease		
Frequent or recurrent headaches		
Loss of consciousness		
Convulsions or seizures		
Head injury		
Stroke		
Paralysis or muscular weakness		
Tremor or abnormal movements		
Difficulty with coordination		
Difficulty in walking		
Difficulty in speaking		
Double vision or loss of vision		
Numbness		
Difficulty with memory		
Dizziness		
MOOD		
Have you recently...		
Experienced severe anxiety, panic or phobias?		
Found it hard to concentrate?		
Felt unable to enjoy your usual activities?		
Had a weight change or eating disorder?		
Had insomnia or excessive daytime sleepiness?		
Thought yourself undeserving or worthless?		
Felt excessively fatigued?		
Felt depressed?		
Have you ever:		
Had a nervous breakdown or psychiatric care?		
Had a drug or alcohol problem?		
Would you like consultation with a mental health professional?		
SPECIAL SENSES		
Have you ever had:		
Glaucoma		
Other major eye disease		
Deafness		
Abnormal noises in the ear		
ALLERGY & IMMUNOLOGY		
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)		

	YEAR
Date last immunized for Tetanus-Diphtheria (every 5-10 yrs.)	
Pneumococcal Pneumonia (Pneumovax)	
Influenza (annual - Fall)	

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_____