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DATE	PLEASE	ENTER THE	NAME O	F THE DOCTO	R SEEING YO	U TODAY		F	PATIENT NUM	BER
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WHO TO NOTIFY IN CASE OF AN EN ADDRESS				CITY			STATE		ZIP	
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1. PRIMARY INSURANCE CO.			(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			PHON	IE .	
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ADDRESS				CITY			STATE		ZIP	
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RELATIONSHIP TO PATIENT	POLICY	HOLDERS EMPLO	DYER							
POLICY#		GROUP#						EFFE	CTIVE DATE	
2. SECONDARY INSURANCE CO.								PHON) 	
ADDRESS				CITY			STATE		ZIP	
POLICY HOLDER NAME				DATE OF	BIRTH			SSN		
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POLICY#		GPOUR #						CCC.	CTIVE DATE	
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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 <u>all</u> questions. If you do not know the answe mark in the space. <u>Please leave no blanks</u> .	er, or do not un	nderstand the question, ins	ert a question
GENERAL HEALTH AND HABITS Characterize your present health status: Excellent ()	/ery Good ()	Average () P	oor ()
Exercise	Nutrition	Average ()	001 ()
Do you exercise regularly? Yes () No ()		years ago5 years ago .	now
How long have you exercised on a regular basis?	Your appetite: Are there foods	Éxcellent () Good () Fair (s you avoid (or limit) for health reaso) Poor() ns?
Smoking		mount of alcohol you drink regularly:	
Do you smoke? Yes() No() How many per day		drinks* per day	
Cigars () Other (specify)	fee, tea, cola) you drink glasses, cups, or cans		
	* one drink = 1	can beer, 4 oz. wine or 1 oz. hard lie	quor
PAST MEDICAL AND SURGICAL HISTORY List chronologically all the surgery you have had, indicating the	e nature of each	n operation and where and wh	en it was done.
(Be accurate and complete. Consult family, friends, physicians			
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	e 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			NO	YES ? DATE
RESPIRATORY		ONSET	PHYSICIAN'S COMMENT	DIGESTIVE		OF
Have you ever had any of the		ONSET	(leave Blank)	Do you often or regularly have		ONSET
following? (If so, indicate when)				Poor appetite		
Pneumonia				Trouble swallowing		
Severe bronchitis				"Heartburn"		
Pleurisy				Regurgitation of food or bile		
Tuberculosis skin test (Pos or Neg)				Nausea or vomiting		
Tuberculosis (infection or contact)				Abdominal pain		
Asthma (wheezing)				Constipation		
Chronic bronchitis				Diarrhea		
Emphysema				Has there been any change in your		1
Other lung trouble				bowel function in the last 6 mos.?		
Exposure to dangerous dust				Have you ever had any of the	=	1
or fumes				following? (If so, indicate when.)		
Trouble breathing				Hiatal or esophageal hernia		
Excessive snoring				Duodenal or gastric ulcer		1
Do you have chest pain?				Vomiting of blood	-	
Abnormal chest x-ray?				Black or tarry stools		+
Have you ever coughed up blood?				Blood in your stool		1
Do you often or regularly				Yellow jaundice		+
Cough?				Liver trouble or hepatitis		1
Raise sputum?				Gallbladder trouble or stones		1
Do you often get chest colds?				Persistent diarrhea or colitis		
When was your last chest x-ray?				Diverticulitis		
,				Parasitis infection		
CIRCULATORY				Hernia	-	
Have you ever had any of the				Other digestive disease		
following? (If so, indicate when.)				When was your last:		
Chest pain				Upper Gl x-ray		
Heart trouble				Barium enema x-ray		
Heart attack (coronary)				Gallbladder x-ray/ultrasound		
Angina pectoris				UGI endoscopy (gastroscopy)		
High cholesterol				Colonoscopy		
High blood pressure				JOINTS		
Blackouts				Have you ever had any of the		
Racing of heart				following? (If so, indicate when.)		
Rheumatic fever				Muscle pain		
Heart failure				Back pain		
Abnormal electrocardiogram				Joint pain		
Swelling of your ankles				Joint swelling		
Have you ever taken heart or				Gout		
water pills?				Has your doctor diagnosed arthritis,		
				rheumatism?		
ENDOCRINOLOGY						
Have you ever had any of the				CUTANEOUS		
following? (If so, indicate when.)				Have you ever had		
Hormone problems				skin rashes		
Thyroid disease				skin cancer		
Diabetes		1				

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!

URINARY OF Have you ever had or been told you had any of the following? (if so, indicate when.) Kidney disease or neightris Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine Kidney shores. Unmany infection. Protein or albumin in unine Blood or pus in urine How many times day. Ulfury. Difficulty in validing. Difficulty in validing. Difficulty with memory. Diff		NO	YES			NO	YES
Uniforce of the following? (if so, indicated without, which is the property of the following? (if so, indicated without, which is the problem or ablumin in urine. Blood or pus in urine. Kidney disease or neightris. Protein or ablumin in urine. Blood or pus in urine. Kidney sideses. Syphilis or gonorithes. Uninary infection. Production ablumin in urine. Syphilis or gonorithes. Uninary infection. Syphilis or gonorithes. Which was the standard of the structure of the structure. Syphilis or gonorithes. Syphilis or gonorithes. Syphilis or gonorithes. Which was the structure of the st							
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indicate when) Kichey disease or nephritis Frotein or albumin in urine Blood or pus in urine Kichey stones Kichey	Have you ever had or been told you		ONSET	(leave Blank)	Have you ever had any of the		ONSET
Frequent or recurrent headaches Convolvisions or seizures	had any of the following? (If so,				following? (If so, indicate when.)		
Protein or abunnin in urine Blood or pus in urine Kidney stones Widney widnes Widney W	• • •				Neurological disease		
Protein or albumin in urine Blood or pus in urine Kidney stones Widney W	, , , , , , , , , , , , , , , , , , ,				Frequent or recurrent headaches		
Blood or pus in urine Kinney stones Lifnary infection Prostate trouble Stroke Deficulty in walking Difficulty in walking Double vision or loss of vision Numbroses Universe Uni	· · · · · · · · · · · · · · · · · · ·				Loss of consciousness		
Sichley shones Unimary infection Prostate trouble Tremor or abnormal movements Difficutly with coordination Difficutly with coordination Difficutly in speaking Difficutly in waking Difficutly in waking Difficutly with coordination Difficutly with memory Diff					Convulsions or seizures		
Unitary infection Prostate trouble Tremor or abnormal movements Difficulty with coordination Difficulty in walking . Difficulty in speaking . Double vision or loss of vision . Numbness . Difficulty with memory . Dizziness	· .				Head injury		
Prostate trouble Syphilis or gonomena How many times do you urinate: at right? during the day Do you have discomfort passing urine? Have you ever had a kidney x-ray ((LVP.) OBSTETRIC & GYNECOLOGICAL Have you ever had urino(s), cyst(s), or or other broast disease? How many times have you been preparant? (including miscerriages)? How many times have you been personal? (including miscerriages)? How many times have you been personal? (including miscerriages)? How many times have you been personal? (including miscerriages)? How many times have you been personal? (including miscerriages)? How many times thave you been personal or after intercourse? At what age did you begin to menstruate? Have you ever had toxemia? Have you ever had dixemia? Have you ever had a hysterectomy? Are you now tabling hormones or birth control pills? When was your last Pap smear? Have you ever had a hysterectomy? The one before? Have you ever had instead present and the present of the properties of the pro	,				1		
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(Pneumovax)					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
,	,				(Pneumovax)		
					Influenza (annual - Fall)		-

CURRENT M	IFDICATIO	NS							
List all the medic	cations you are	e NOW taking. nd complete; tl	herefore consult with your		of each dose, how often taken, a pist, physician. (Do not neglect a				
N	lame of medic	ine	Strength of each	n dose	How often taken	Wi	nen began ta	king	
PERSONAL HIS				List the a	reas you have lived in chron	ologically, giv	ving dates:		
Where were you Have you ever liv			hroad?		Area		From	То	
(If so, give details									
	- /								
What is your occ	upation?								
Do you enjoy you	ur work(retirer	nent)?							
Have you ever w				List your	past occupations chronologi	cally, giving o	lates:		
in any capacity technician)?	-		егк,		Occupation		From	То	
What is the highe									
have attained?									
			exposed to at your place of	:					
work?									
FAMILY HEA	LTH								
		formation ab	out the health of your in	nmediate fa	mily:				
RELATION	Age if alive	Age at death		St	ate of health or cause of dea	ath			
Mother									
Father Brothers									
and									
Sisters									
Spouse									
Children									
•		-	of the following? (If so, in		• *				
Diabetes Cancer (specify type if know			·						
				Any obscure or unusual disease					
-	Allergies Blood disease								
					A disease which "runs in	-			
"Heart Attack" High blood pressure				Kidney disease					

Signature of Patient_