Updated Patient Information For 2015

Patients Name: ______________________________ Date : ________________

Has anything changed since 2014

Address	yes / no	____________________
Phone	yes / no	____________________
Cell	yes / no	____________________
Pacemaker	yes / no	
Insurance	yes / no	____________________
Employer	yes / no	____________________
Occupation	yes / no	____________________
Marital Status	yes / no	Married Widowed Single Separated Divorced
Spouse	yes / no	____________________
Email	yes / no	____________________
Emergency Contact Person	yes / no	____________________
Emergency Number	yes / no	____________________

I have reviewed all the above information and consent that it is correct

____

Patients and/ or Legal Guardian Signature

____

Witness Signature

2015

Name: ______________________________ Date: ____________________ DOB: ______________

Due to recent changes in the healthcare reform, we are asked to obtain the following information on each patient the treats in our office. Every year this information must be updated per Government Officials. Thank you.

Language: English____ Spanish____ Indian____ French____ German____ Other ______________

Race: White____ Black /African American ____American Indian/Alaska Native____ Asian____
Native Hawaiian/Pacific Islander____ Hispanic /Latino____ Decline to Answer____

Ethnicity: Hispanic/Latino____ Not Hispanic/Latino____ Decline to Answer____

Best Way to Contact you: Home Phone ____ Cell ____Email ____Other__________________________

Patient History: Are you seeing anyone else for other problems/health conditions? Yes / No

Please list the problems/s, date problem/s began, and Provider/s treating you for the condition/s:

____

Past Health History:Have you….	Yes	No	If yes, include date & provider seen
….been hospitalized in the last 5 years?	___	___	______________________________
….been diagnosed with Diabetes? Type I____ Type II____	___	___	______________________________
….do you have a pacemaker?	___	___	

Do you Smoke? Never_______ Former Smoker_______ Current/every day Smoker_______ Current Some day Smoker_______

Mediations: What medications are you currently taking? Include vitamins, herbs, minerals…..

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by:

Please be as specific as possible:

____

____

Do you have allergies? Food____ Environmental____ Medication____ List Type of Allergy and Reaction

Primary Care Doctor:

If you mark yes…please briefly explain in blank space next to questions:

Weight changes:	Y / N	______________________________
Fevers / Chills:	Y / N	______________________________
Sweats:	Y / N	______________________________
Bleeding / Bruising:	Y / N	______________________________
Bowel / Bladder Dysfunction:	Y / N	______________________________
Rashes / Skin Disorders:	Y / N	______________________________
Masses / Tumors:	Y / N	______________________________
Shortness of Breath/Chest Pain:	Y / N	______________________________
Dizziness:	Y / N	______________________________
Fainting:	Y / N	______________________________

Family History: Please Denote your Father or Mother's side of the family			***Mother / Father***	
Diabetes:	Y / N	______________________________	_____	_____
Thyroid Disease:	Y / N	______________________________	_____	_____
Tuberculosis:	Y / N	______________________________	_____	_____
Kidney Disease:	Y / N	______________________________	_____	_____
Liver Disease:	Y / N	______________________________	_____	_____
High Blood Pressure:	Y / N	______________________________	_____	_____
Heart Disease:	Y / N	______________________________	_____	_____
Autoimmune Disease:	Y / N	______________________________	_____	_____
Rheumatoid Arthritis:	Y / N	______________________________	_____	_____
Cancer:	Y / N	______________________________	_____	_____

Vitals (for office use only)Height ________ Weight ________ Blood Pressure ________ Pulse_______ Respirations_______