PATIENT INFORMATION

NAME: _____ NEW PATIENT? Y / N _____
(First) (Middle) (Last)

SS# _____ DATE OF BIRTH: _____ AGE: _____ SEX: _____

MARITAL STATUS: S / M / O ALLERGIES: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL: _____ EMAIL: _____

RACE: B / W / H / NA / ASIAN PREFERRED CONTACT: _____ PRIMARY LANGUAGE: _____

NEAREST RELATIVE (Not living with you): _____ Phone: _____

EMPLOYER: _____ Employed Full Time: _____

Address: _____ Part Time: _____

_____ Student Full Time: _____

Phone: _____ Ext.: _____ Part Time: _____

RESPONSIBLE PERSON: _____
(Responsible for Bills)

INSURANCE INFORMATION

PRIMARY: _____ SUBSCRIBER: _____ RELATIONSHIP: _____

SECONDARY: _____ SUBSCRIBER: _____ RELATIONSHIP: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim. I also authorize the release of information to my insurance company for purposes required by my insurance contract. I permit a copy of this authorization to be used in teh place of the original.

DATE: _____ SIGNATURE: _____

I hereby authorize Dr. Ramsay to apply for benefits on my behalf for covered services rendered by her , or by her order. I request that payment from my insurance company be made directly to Dr. Ramsay (or to party accepting assignment).

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the origianl. This authorization may be revoked by either myself or my insurnace company at any time in writing.

DATE: _____ SIGNATURE: _____
Patient, parent or guardian

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO ID/DRIVER'S LICENCE WITH THIS DOCUMENT

(All information is strictly confidential)

FAMILY HISTORY

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITILIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates._____

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS

Check which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date

HEALTH HISTORY

(Confidential)

Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is your reason for visit? _____

SYMPTOMS Check symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL

- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Pain

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore That Won't Heal

MEN ONLY

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

WOMEN ONLY

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Bleeding
- ☐ Other

Date of Last Menstrual Period _____

Date of Last Pap Smear _____

Have you had a Mammogram? _____

Are you pregnant? _____

Number of Children _____

CONDITIONS Check conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

Pharmacy Name _____ Phone _____

ALLERGIES To medications or substances