SoutheastHEALTH

PATIENT INFORMATION FORM

Today's Date: _____

Patient Name: _____ Date of Birth: (M/D/Y) _____

Previous and/or Maiden Name: _____ Social Security Number: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

[ ] I consent for the staff to leave voicemail(s) pertaining to my health information.

Email: _____ Preferred Language: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Race: _____ Ethnicity: _____

Is today's visit associated with an accident? (If no, proceed to Insurance Section)

Type of Accident: [ ] Fall [ ] Work-Related [ ] Auto [ ] Other: _____

Accident Date: _____ Accident Time: _____

INSURANCE

Primary Insurance Company: _____ Policy Holder's Name: _____

Policy Holder Name: _____ Group Number: _____

Policy Holder Relation to Patient: _____ Policy Holder DOB: _____

Policy Holder SSN: _____ Policy Holder Employer: _____

Policy Holder Occupation: _____ If Retired, Date of Retirement: _____

Secondary Insurance Company: _____ Policy Holder's Name: _____

Policy Holder Name: _____ Group Number: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Relation to Patient: _____

Birthdate: _____ Phone Number: _____

Next of Kin Contact Name: _____ Relation to Patient: _____

Birthdate: _____ Phone Number: _____

Medical Record #: _____

FOR OFFICE USE ONLY

NEW PATIENT HISTORY FORM

Patient Name: _____

Date of Birth: _____

Reason for Visit: _____

Primary Care Physician: _____

Referring Physician: _____

Any religious, cultural or spiritual beliefs that may affect your treatment? ☐ Yes ☐ No

If yes, please explain: _____

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Clots
- ☐ Cancer, type: _____
- ☐ CVA (stroke)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Valve Disease
- ☐ Other: _____

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ Angioplasty
- ☐ Angioplasty with Stent
- ☐ Appendectomy
- ☐ Arthroscopy Knee
- ☐ Back Surgery
- ☐ CABG (Heart Bypass)
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (Gall Bladder)
- ☐ Colectomy (Removal of Colon)
- ☐ Colostomy Placement
- ☐ Ear Tubes
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Lasik
- ☐ Liver Biopsy
- ☐ Open Reduction Internal Fixation
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

☐ Other: _____

Medical Record #: _____

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NEW PATIENT HISTORY FORM

Patient Name: _____

Date of Birth: _____

SOCIAL HISTORY

Been exposed to Hazardous Materials (example: asbestos, radiation, TB, tec.): ___ Yes ___ No

Special Diet Restrictions: _____

Frequency of Exercise: [ ] None/Occasionally [ ] 1-2 times/week [ ] 3-5 times/week [ ] Everyday

Type of Exercise (ex: aerobic, walking, martial arts, etc.)**:** _____

Drug Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit:_____

Type of Drug(s) (ex: acid, cocaine, marijuana, etc.): _____

Route of Drug(s) (ex: , inhale, in muscle, oral, etc.):_____

Alcohol Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit:_____

Alcohol Type:_____ Drinks Per Week:_____ Years Used: _____

Tobacco Usage: [ ] Never [ ] Occasionally [ ] Regularly [ ] Used in the past – Year Quit: _____

Type:_____Packs/Cans Per Day:_____Years Used: _____

Exposed to second hand smoke: [ ] Yes [ ] No

Medical Record #: _____

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NEW PATIENT HISTORY FORM

Patient Name: _____

Patient DOB: _____

FAMILY HISTORY (Please check all that apply)

___	ADD/ ADHD	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Alcoholism	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Allergies	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Alzheimer's Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Asthma	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Blood Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Breast Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Colon Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	CVA (stroke)	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Depression	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Developmental Delay	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Diabetes	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Eczema	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Hearing Deficiency	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Heart Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	High Blood Pressure	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Hyperlipidemia	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Irritable Bowel Disease (IBS)	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Learning Disability	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Lung Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Mental Illness	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Migraines	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Obesity	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Osteoarthritis	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Prostate Cancer	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	PVD (Blood flow problems in arms, legs, or neck)	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Renal Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Seizure Disorder	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____
___	Thyroid Disease	___	Mother	___	Father	___	Brother	___	Sister	___	Other _____

Other: _____

Medical Record #: _____

FOR OFFICE USE ONLY

MEDICATION & ALLERGIES FORM

Patient Name: _____

Date of Birth: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Location: _____

ALLERGIES

☐ None ☐ Penicillin ☐ Sulfa Drugs ☐ IVP Dye

☐ Food: _____

☐ Other: _____

MEDICATIONS

NAME	DOSAGE	HOW OFTEN?

Medical Record #: _____

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SoutheastHEALTH

CURRENT CONDITIONS FORM
ORTHOPEDIC CLINIC

Patient Name: _____

Date of Birth: _____

Please check all that apply

General:
- ☐ Weight Change > 10lbs
- ☐ Fever
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Blood Transfusion

Head & Neck:
- ☐ Visual Changes
- ☐ Dizziness
- ☐ Double Vision
- ☐ Sinus Problems
- ☐ Frequent Nosebleeds
- ☐ Ear Pain
- ☐ Trouble Hearing
- ☐ Ringing in Ears
- ☐ Hoarseness
- ☐ Persistent Sore Throat
- ☐ Mouth Sores
- ☐ Swollen Glands

Respiratory/Lungs:
- ☐ Stop Breathing During Sleep
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Cough
- ☐ Sore Throat

Reproduction:
- ☐ Blood in semen (men)
- ☐ Inability to Have Erection
- ☐ Inability to Reach Climax
- ☐ Infertility
- ☐ Painful Intercourse
- ☐ Decreased Sexual Desire
- ☐ Sexually Transmitted Disease

Women:
- ☐ Breast Pain/Lumps
- ☐ Pelvic Pain
- ☐ Vaginal Discharge
- ☐ Frequent Sweats/Hot Flashes
- ☐ Menstrual Problems
- ☐ Menopause
- ☐ Pregnancy Problems
- ☐ Baby Weighing 9lbs or More

Skeletal:
- ☐ Gout
- ☐ Back Pain (Major)
- ☐ Neck Pain (Major)
- ☐ Weakness of Arm / Leg
- ☐ Joints Swelling/ Stiffness
- ☐ Deformities of Back/ Extremities

Heart/Vascular:
- ☐ Chest Pain/Tightness
- ☐ Irregular Rapid Heart Beat
- ☐ Smothering Feeling at Night
- ☐ Ankle Swelling

Stomach/Bowel:
- ☐ Black/Bloody Stool
- ☐ Nausea/Vomiting (Frequent)
- ☐ Frequent Heart Burn/ Acid (GERD)
- ☐ Abdominal Pain
- ☐ Diarrhea (Frequent)
- ☐ Constipation
- ☐ Difficulty Swallowing
- ☐ Vomiting Blood

Kidney/Bladder:
- ☐ UTI
- ☐ Urinary Incontinence
- ☐ Urinary Hesitancy
- ☐ Frequent Urination
- ☐ Urinary Urgency
- ☐ Nocturia
- ☐ Dysuria
- ☐ Hematuria
- ☐ Urinary Retention

Neuro:
- ☐ Numbness/Tingling
- ☐ Severe Frequent Headaches
- ☐ Abnormal Coordination
- ☐ Trouble with Speech
- ☐ Forgetfulness/ Confusion

Skin & Hair Problems:
- ☐ Changes in Hair/ Hair Loss
- ☐ Major Skin Problems
- ☐ Wounds Not Healing
- ☐ Persistent Rash
- ☐ Changes in Moles

Psych/Social:
- ☐ Feeling Blue/ Discouraged
- ☐ High Anxiety/Stress
- ☐ Loss of Friends
- ☐ Feeling Life Has No Purpose
- ☐ Feeling Others Are Talking About You
- ☐ Feeling Fear
- ☐ Hearing Voices
- ☐ Marital or Relationship Problems
- ☐ Early Morning Awakenings

☐ I have reviewed the review of systems for this patient.

Provider Signature: _____