B12, Botox, HRT, Weight Loss

122 S. Goose Creek Blvd, Ste B
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WELCOME

PATIENT INFORMATION

Date: ______________________________

Name: ____
First Middle Last

Mailing Address: ____
Street Name

____
City State Zip Code

Phone # (H)__________________________ (W)__________________________ (Other)__________________

What number do you prefer us call? ❑ Home ❑ Work ❑ Other

Email address: ____

Date of Birth: _____/_____/__________ Sex: ❑ Male ❑ Female SS#: ____________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: ______________________________ Employer: ______________________________

Employer Address: ____ Phone: ____________________

Emergency contact: Name: ____ Relation: ________________

Phone # (H)__________________________ (W)__________________________ (Other)__________________

How did you hear about our practice? ____

PATIENT DEMOGRAPHICS

As a medical office we are required to report patient demographics to insurance agencies as requested. Please answer the following questions.

Primary Language: ______________________________ Secondary Language (if applicable): ______________________________

Ethnicity: Hispanic or Latino Non Hispanic or Non Latino Decline to Specify

Smoking: Current Everyday Smoker Current Someday Smoker Ex-Smoker Heavy Tobacco Smoker
Light Tobacco Smoker Never Smoked Tobacco Smoker, Current Status Unknown Unknown if ever smoked
Smoking Start Date: ____________________

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

____

Patient Name (Signature) **Date**

Patient Name: ____ DOB: ___/___/_____ Date: ___/____/_______

FAMILY HISTORY

The following questions should be answered ONLY if one of your immediate family members has experienced one of these conditions/diseases. Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑ Heart Disease ___________________ ❑ Diabetes ___________________
❑ Cancer ___________________ ❑ Arthritis ___________________ ❑ Other ______________________________

HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) ____

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV
❑ Alcoholism
❑ Allergy Shots
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorders
❑ Breast Lump
❑ Bronchitis
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Chemical Dependency
❑ Chicken Pox
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fractures
❑ Glaucoma
❑ Goiter
❑ Gonorrhea
❑ Gout
❑ Heart Disease
❑ Hepatitis
❑ Hernia
❑ Herniated Disc
❑ Herpes
❑ High Cholesterol
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Migraines
❑ Miscarriage
❑ Mononucleosis
❑ Multiple Sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's Disease
❑ Pinched Nerve
❑ Pneumonia
❑ Polio
❑ Prostate Problems
❑ Prosthesis
❑ Psychiatric Care
❑ Rheumatoid Arthritis
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Other _______________________________
❑ Stroke
❑ Suicide Attempt
❑ Thyroid Problems
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors/Growths
❑ Typhoid Fever
❑ Ulcers
❑ Vaginal Infections
❑ Venereal Disease
❑ Whooping Cough

Please list any medications you are currently taking, including supplements:

____
____
____
____

Please list any surgeries and/or hospitalizations you have had (type & date):

____
____
____
____

Please list any allergies: ____

What is your daily/weekly intake of the following? Caffeine ___ cups/day Alcohol ____ drinks/week Cigarettes _ packs/day

____

Patient Name (Signature) **Date**

Patient Name: ____ **DOB:** ___/___/_____ **Date:** ___/____/_______

REVIEW OF SYSTEMS

Allergic-Immunologic: ❑None known
❑Hives/Eczema ❑Hay Fever ❑Catch Colds Easily ❑Frequent Sinus Trouble ❑Frequent Influenza
❑HIV ❑AIDS ❑Fever ❑Allergies (if yes please list below)

Please list any allergies: ____

Cardiovascular: ❑None known
❑Murmur ❑Chest Pain ❑Palpitations ❑Dizziness ❑Shortness of Breath
❑Swollen Ankles ❑Heath Attack ❑Irregular Heart Beat ❑Pressure Over the Chest ❑Pain Down the Left Arm
❑High Triglycerides ❑High Cholesterol ❑Perfuse Sweating ❑Nausea ❑Vomiting
❑Low Blood Pressure ❑Fainting Spells ❑High Blood Pressure ❑Difficulty lying flat

Constitutional:❑None known
❑Weight Loss ❑Fatigue ❑Fever

Ear, Nose, Throat:❑None Known
❑Difficulty Hearing ❑Buzzing in Ears ❑Ringing in Ears ❑Vertigo ❑Sinus Trouble ❑Nasal Stuffiness
❑Hearing Loss ❑Ear Pain ❑Mouth Sores ❑Horsens ❑Nose Bleeds ❑Dental Problem
❑Frequent Sore Throat ❑Difficulty Swallowing

Endocrine:❑None Known
❑Loss of Hair ❑Heat/Cold Intolerance ❑Hypothyroidism ❑Hyperthyroidism ❑Diabetes ❑Goiter

Eyes: ❑None Known
❑Glasses/Contacts ❑Eye Pain ❑Light Bothers Eyes ❑Double Vision ❑Cataracts ❑Vision Problems
❑Blurred Vision ❑Glaucoma

Gastro-Intestinal:❑None Known
❑Heartburn/Reflux ❑Nausea/Vomiting ❑Constipation ❑Change in BMs ❑Diarrhea
❑Black/Bloody BM ❑Gallbladder Problem ❑Liver Problem ❑Hepatitis ❑Distress from greasy food
❑Ulcers ❑Heartburn ❑Hiatal Hernia ❑Colitis ❑Blood in Stool
❑Colon Cancer ❑Abdominal Pain ❑Burning in Stomach ❑Pancreatitis ❑Jaundice
❑Pain over Stomach ❑Mucus in Stool

Genitourinary:❑None Known
❑Burning/Frequency ❑Blood in Urine ❑Erectile Dysfunction ❑Abnormal Discharge ❑Leakage
❑Incontinence ❑Kidney Infection ❑Sexual Difficulty ❑Kidney Stones ❑Loss of Libido

Hematology/Lymp:❑None Known
❑Easy Bruising ❑Gums Bleed Easily ❑Enlarged Glands ❑Anemia ❑Bleeding Disorder
❑Sickle Cell Anemia ❑Lymphoma

Musculoskeletal:❑None Known
❑Joint Pain/Swelling ❑ Stiffness ❑ Muscle Pain ❑ Neck Pain ❑ Stiff Neck ❑ Back Pain
❑Osteoarthritis ❑Rheumatoid Arthritis ❑ Bone Spurs ❑Broken Bones ❑Compression Fracture ❑Head Injury
❑Back Injury ❑Spinal Trauma ❑Birth Trauma ❑ Birth Defects ❑Cancer ❑Muscle Weakness
❑Muscular Dystrophy ❑ Scheuerman's Disease ❑Scoliosis ❑Lupus ❑Spinal Bifida ❑Spondylolisthesis
❑Arthritis ❑ Neck Injury ❑Osteoporosis

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient Name (Signature) **Date**

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance company, your health information on this form may be shared with them. Your health information which your insurance company sees will be kept confidential by them.