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PATIENT INFORMATION

NAME _____DATE _____

MALE _____ FEMALE _____ BIRTHDATE _____

SOCIAL SECURITY NUMBER -- **OPTIONAL** _____

IF CHILD, PARENT'S NAME _____

MAILING ADDRESS: _____

PHYSICAL ADDRESS : _____

PHONE : HOME _____ WORK _____

EMAIL : _____

OCCUPATION/EDUCATION _____

SPOUSE/SIGNIFICANT OTHER _____

CONTACT NAME & PHONE FOR EMERGENCY _____

PRIMARY PHYSICIAN _____ PHONE _____

What are the most important health concerns you have at this time ? Please list in order of importance

Brief Description When symptoms started What do you think is causing them ?

1. _____

2._____

3._____

4. _____

5. _____

Regarding your chief complaint:

1. Have your symptoms increased or decreased since the onset ? _____

2. What has helped relieve the symptoms ? _____

_____

_____

3. What time of day are your symptoms most severe ? _____

4. How many days per week do you experience your symptoms ? _____

5. How has this problem affected your work home and social life ? _____

_____

_____

6. What type of treatment (medical or non-medical) have you received for this problem ? _____

MEDICATIONS YOU ARE CURRENTLY TAKING

	Medication	Dosage	Frequency	# of Years Used
1.				
2.				
3.				
4.				
5.				

(continue on reverse side if necessary)

Number of courses of antibiotics taken : In last 3 years _____ In your life _____

VITAMINS/SUPPLEMENTS YOU ARE NOW TAKING :

1.
2.
3.
4.
5.
6.
7.

(continue on reverse side if necessary)

TREATMENTS, MEDICATIONS & SUPPLEMENTS used in the past year which were not helpful :

1.
2.
3.

ALLERGIC REACTIONS TO :	SYMPTOMS/REACTIONS
Drugs:	
Foods:	
Chemical/Environmental Factors:	
Animals:	

HISTORY OF ILLNESSES/CONDITIONS

PLEASE CIRCLE

Alzheimer's

Anemia

Asthma

Blood Transfusion

Cancer –

Type _____

Chicken Pox

Diabetes

Epilepsy

Heart Disease

Hepatitis

Herpes (genital)

Herpes (oral)

Herpes (shingles)

Hypertension

Kidney Disease

Mononucleosis

Pneumonia

Polio

Rheumatic Fever

Rubella (German measles)

Rubeola (Red measles)

Scarlet Fever

Sexually Transmitted Disease

Stroke

Thyroid

Tuberculosis

Whooping Cough

Other:_____

HOSPITALIZATIONS / SURGERIES

Year	Major Event	Hospital	

IMMUNIZATIONS YOU HAVE HAD

----Chicken pox

----Diphtheria/ Tetanus (TD)

_____DPT

_____Hepatitis

_____Influenza

_____Mumps

_____Other : _____

----- Polio injection (Salk)

----- Pneumovax

_____ Polio oral (Sabin)

_____ Rubella (German measles)

_____ Rubeola (Red measles)

_____ Smallpox (vaccination)

MOST RECENT STUDIES OR TESTS

TEST	DATE or YEAR
Physical Exam	_____
Blood Chemistry/ Count	_____
Cholesterol Test	_____
Urinalysis	_____
Mammogram	_____
Pap Smear	_____
X-ray	_____
CAT Scan	_____
MRI	_____
Ultrasound	_____
Colonoscopy	_____
EKG	_____
TB Test	_____
Other: _____	_____

DIET, EXERCISE & SOCIAL HABITS

Describe your typical exercise regime (frequency/duration) _____

_____

_____

Have you lost or gained more than 10 pounds in the past year ? _____

How much water do you drink in a typical day ? _____

How many times per week do you eat/drink the following :

pop, soft drinks, sweetened beverages

(Gatorade, Sobe, etc) _____

sugar _____

pastries, donuts, cookies, etc _____

candy _____

artificial sweeteners _____

(Nutrisweet, diet pop, etc.)

preserved meats _____

(bacon, hotdogs, lunch meat)

red meat _____

chicken _____

fish _____

milk _____

butter _____

eggs _____

cheese _____

yogurt _____

canned foods _____

cooked vegetables _____

fast food restaurants _____

fresh vegetables _____

garlic _____

onion _____

corn _____

soy products _____

legumes _____

bread _____

wheat _____

white flour _____

coffee _____

tea _____

olive oil _____

other oil _____

margarine _____

Hobbies ?	
Travel ?	
Drug use ? Which drugs ?	
Alcohol consumption ?	
Tobacco use ?	
Occupational Hazard ?	

STRESS / TRAUMA Significant Event ? _____

_____

_____

What do you do to cope with stress ? _____

_____

_____

MENTAL / EMOTIONAL HEALTH :

Poor concentration ?_____

Memory problems ? _____

Anxiety / nervousness ? _____

Tension / Stress ? _____

Mood swings ? _____

Depression ? _____

Worrier ? _____

Cry often ? _____

Difficulty making decisions ? _____

Do you feel safe in your home ? _____

SLEEP

Hours of sleep per night ? _____

Trouble falling asleep ? _____

Wake in the middle of the night ? _____

Do you fall back asleep easily ? _____

Waking rested ? _____

Treated for emotional problems ? _____ Chronic fatigue ? _____

Night sweats ? _____7

REVIEW OF SYSTEMS

Name: _____ Date : _____

Please indicate "**C**" if it is a **current** problem, **"P"** if it is a **past** problem

BLOOD/ PERIPHERAL VASCULAR

_____ Easy bruising or bleeding
_____ Deep leg pain
_____ Varicose veins
_____ Anemia
_____ Cold hands/feet
_____ Thrombophlebitis

BREASTS

_____ Lumps
_____ Nipple discharge
_____ Pain/tenderness
_____ Swelling
_____ Nipple retraction
_____ Self Exam

CARDIOVASCULAR

_____ Heart disease
_____ Blood clots in lungs
_____ High Blood pressure
_____ Chest pressure or tightness
_____ Chest pain (angina) or heaviness
_____ Palpitations
_____ Rapid heart rate at rest
_____ Irregular heart rate
_____ Heart murmur
_____ Swollen ankles/ feet in evening
_____ Leg cramps when sleeping
_____ High cholesterol or fats
_____ Blue / cold hands or feet
_____ Calf pain while walking

_____ Ear discharge
_____ Excess wax
_____ Recurrent infections

ENDOCRINE

_____ Thyroid problems
_____ Hypoglycemia
_____ Excessive thirst
_____ Fatigue
_____ Hair loss
_____ Heat/cold intolerance
_____ Diabetes
_____ Excessive hunger
_____ Easy weight gain

EYES

_____ Color blindness
_____ Glaucoma
_____ Cataracts
_____ Wear glasses
_____ "See" spots / stars
_____ Blurriness
_____ Double vision
_____ Tearing/ dryness
_____ Itchy eyes
_____ Red eyes
_____ Strain / pain
_____ date of last exam

_____ Rheumatic fever
_____ Phlebitis
_____ Fainting

EARS

_____ Impaired Hearing
_____ Hearing aids
_____ Earaches
_____ Ringing in ears / tinnitus
_____ Dizziness / vertigo

SKIN

_____ Color/texture/moisture change
_____ Sores
_____ Itching
_____ Severe acne
_____ Cancer
_____ Easy bruising / bleeding
_____ Change in fingernails
_____ Hair loss
_____ Oiliness

LYMPH SYSTEM

_____ Enlargement
_____ Redness
_____ Pain / tenderness

HEAD

_____ Trauma / injury
_____ Headache / migraines
_____ Dizzy or light-headed
_____ Fainting
_____ Loss of consciousness
_____ Feeling of spinning
_____ Seizure disorder
_____ Jaw / TMJ problems

IMMUNE

_____ Chronic Fatigue
_____ Chronically swollen glands
_____ Reaction to vaccines

GASTROINTESTINAL / DIGESTION

_____ Weight loss/gain this year
_____ Loss of appetite
_____ Compulsive eater
_____ Stomach ulcers
_____ Heartburn
_____ Indigestion
_____ Food intolerances
_____ Bloating or belching
_____ Flatulence - gas/bloating
_____ Nausea / vomiting
_____ Vomiting blood
_____ Abdominal pain
_____ Change in stool habits
_____ Bowel movements in night
_____ Constipation
____ Straining w/bowel movements
_____ Diarrhea
_____ Anti-acids / laxatives
_____ Black stools
_____ Rectal pain/itching/bleeding
_____ Hemorrhoids
_____ Hernia (umbilical or hiatal)
_____ Yellow skin / Liver disease
_____ Gall stones
_____ Pancreatitis
_____ Colon polyps
_____ Trouble swallowing

MOUTH & THROAT

_____ Trauma
_____ Neck pain / tenderness
_____ Thyroid problems
_____ Sores in mouth
_____ Bleeding / infected gums
_____ Sore tongue / lips
_____ Dental cavities

_____ Chronic infections
_____ Slow wound healing
_____ Night sweats

FEMALE REPRODUCTION

_____ Year of last Pap exam
_____ Date of last menses
_____ # days of flow
_____ Irregular cycles
_____ Bleeding between cycles
_____ Cramps
----- Clotting
_____ Flow - scant/normal/excessive
_____ Vaginal discharge
_____ Cervical dysplasia
_____ Endometriosis
_____ Ovarian cysts
_____ Uterine fibroids
_____ Sores on external genitalia
_____ Infertility problems
_____ Sexually active
_____ Age of last menses if menopausal
_____ Painful intercourse
_____ Hot flashes
_____ Vaginal dryness
_____ Contraceptive use
_____ # of pregnancies
_____ # of live births
_____ Breast feeding
_____ # of miscarriages
_____ # of abortions
_____ Hysterectomy & Age
_____ Sexually transmitted disease
_____ Sexual concerns

URINARY TRACT

_____ Difficulty / inability to urinate
_____ Pain on urination
_____ Increased frequency
_____ Urgency / inability to hold urine
_____ Frequent infections
_____ Frequency at night # of times _____

_____ Teeth grinding
_____ Frequent sore throat
_____ Difficulty swallowing

MOUTH & THROAT CONT

_____ Hoarseness
_____ Change in taste
_____ Bad breath
_____ Copious saliva
_____ Jaw Clicks

MALE REPRODUCTION

_____ Sexually transmitted disease
_____ Birth control
_____ Hernias
_____ Testicular pain
_____ Testicular self-exams
_____ Prostate problems/ enlargement
_____ Elevated PSA
_____ Discharge or sores
_____ Difficulty with urination
_____ Impotence, sexual concerns

NOSE & SINUSES

_____ Trauma
_____ Sinusitis
_____ Excess nasal drainage
_____ Post nasal drainage (in throat)
_____ Stuffiness / congestion
_____ Obstruction
_____ Nosebleed (s)
_____ Small - loss / change
_____ Breathe through mouth
_____ Frequent colds
_____ Snoring
_____ Allergies / hay fever

RESPIRATORY

_____ Asthma
_____ Pneumonia

_____ Kidney stones
_____ Bladder stones
_____ Flank pain

URINARY TRACT CONT

_____ Hernia (L or R) inguinal or femoral
_____ Cloudy urine
_____ Dribbling
_____ Bed Wetting

MUSCULOSKELETAL

_____ Trauma (fracture/dislocation)
_____ Car accident
_____ Blow to the head
_____ Fall on buttocks
_____ Decreased range of motion
_____ Loss of strength
_____ Stiff or aching muscles/joints
_____ Neck ache / pain
_____ Backache / pain
_____ Arm or hand pain
_____ Numbness / tingling
_____ Sciatic pain – right or left
_____ Arthritis
_____ Swollen joints
_____ Joint pain
_____ Muscle spasms
_____ Cold hands / feet

_____ Bronchitis
_____ Emphysema
_____ Exposure to tuberculosis 10

RESPIRATORY CONT

_____ Pleurisy
_____ Cough
_____ Pain on breathing
_____ Wheezing
_____ Sputum -- irregular
_____ Cough up blood
_____ Shortness of breath at rest
_____ Shortness of breath at exertion
_____ Hiccups

NEUROLOGICAL

_____ Head injury
_____ Frequent headaches
_____ Loss of consciousness
_____ Fainting
_____Numbness – where
_____Tingling – where
_____ Weakness – where
_____ Tremors
_____ Convulsions / seizures
_____ Twitching
_____ Difficulty walking
_____ Speech abnormalities
_____ Decrease / loss of sensation
_____ Poor concentration
_____ Loss of memory
_____ Paralysis

FAMILY HISTORY

Have any of your family members (grandparents, siblings, or children) had significant health issues which you would like to state here ?

RELATION	HEALTH ISSUE

ANY OTHER CONCERNS YOU WOULD LIKE TO ADDRESS ?

ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE

Cash, Checks and Credit cards are accepted

We will provide you with receipts to send your insurance company for reimbursement.

PLEASE BE ADVISED

Dr Seaver does not accept insurance.
We are happy to provide you with an industry standard "super bill" which you may submit to your insurance company.
We cannot guarantee coverage or reimbursement.

This office does not accept Medicare.
We cannot guarantee Medicare coverage or reimbursement.
Medicare patients must agree to be responsible for their bill at time of service.

24 hour notice is required for cancellation of appointments.

Cancellations made with less than 24 hour notification will be charged 50% of appointment fee.

NOTICE OF PRIVACY PRACTICES

I have read the policies and information listed above.

I certify that all the information provided is true and correct.

I understand the potential fee for copying medical records as allowed by law is: $1.40 for the first ten (10) or fewer pages, $.50 each for pages 11-40 and $.33 for each page 41 and after.

I understand that I am responsible for all charges at the time of service.

_____ _____

Signature of Patient or Designated Representative **Date**

_____

Relationship to Patient