

**FOR OFFICE USE ONLY**

CHART # \_\_\_\_\_

PATIENT CODE \_\_\_\_\_

DEPOSIT RECEIVED \_\_\_\_\_

Referred by \_\_\_\_\_

**Please Print**

**PATIENT INFORMATION**

Mr. Mrs. Miss	Last Name		First Name			Middle
Address	Street	Apt. No.	City	State	Zip	Home Phone
SS#	Age	Date of Birth		M/F	Marital Status	
Employed by	Employer's Address		Occupation		Bus. Phone	
Spouse's Name		Employed by		Occupation	Bus. Phone	
Nearest Friend or Relative			Relation to Patient		Phone	
Education	Religious Preference	Are You Eligible for Medicare?		Medicare ID Number		

**RESPONSIBLE PARTY**

**Please complete the section below if someone other than patient is responsible for the payment of services.**

Name	Address	City	State	Zip	
Phone					
Home Phone	Relationship to Patient		Occupation		
Employer	Emp. Address	City	State	Zip	Bus. Phone

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand payment is due when services are rendered and even though I have insurance coverage I am responsible for payment of services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient, Parent or Responsible Party



# FAMILY MEDICAL HISTORY

Relatives	FATHER	MOTHER	SISTER(S)	BROTHER(S)	SONS	DAUGHTERS														
GOOD																				
POOR																				
DECEASED																				
CAUSE OF DEATH																				
AGE AT DEATH																				
ALCOHOLISM																				
ALLERGIES/ASTHMA																				
ANEMIA																				
BLEEDS EASILY																				
DIABETES																				
CANCER/TUMORS																				
EPILEPSY																				
FEMALE PROBLEMS																				
GLAUCOMA																				
GENETIC DISEASE																				
GOUT																				
HEART TROUBLE																				
HIGH BLOOD PRESSURE																				
KIDNEY/BLADDER TROUBLE																				
NERVOUS BREAKDOWN																				
RHEUMATISM/ARTHRITIS																				
STOMACH/DUODENAL ULCERS																				
TUBERCULOSIS																				

**Additional Information:** \_\_\_\_\_

## ADDITIONAL ALLERGY QUESTIONNAIRE

ACNE	_____	IMPETIGO	_____
BACK PAIN	_____	INGROWN TOENAILS	_____
BALDNESS	_____	INJURIES, SERIOUS	_____
BLADDER INFECTION/CYSTITIS	_____	KIDNEY INFECTIONS	_____
BLEEDING TENDENCY	_____	LEARNING DISABILITIES	_____
BOILS	_____	MENTAL ILLNESS	_____
COLITIS – SPASTIC	_____	NOSEBLEEDS	_____
CONCUSSION	_____	OBESITY	_____
CONGENITAL DEFECT	_____	PARASITIC INFECTION (WORMS)	_____
DANDRUFF	_____	POISON IVY OR OAK	_____
DIARRHEA - CHRONIC	_____	POLYPS (SPECIFY LOCATION)	_____
DYSENTERY	_____	PSORIASIS	_____
FISSURES	_____	RINGWORM	_____
FISTULAE	_____	SALIVARY GLAND PROBLEM	_____
FRACTURES	_____	SEXUAL GLAND DYSFUNCTION	_____
GOITER	_____	SHINGLES	_____
HEARING IMPAIRMENT	_____	STROKE/APOPLEXY	_____
HEPATITIS	_____	STYES	_____
HERPES (SPECIFIC LOCATION)	_____	TOXIC CHEMICAL POISONING	_____
HIGH BLOOD FATS (CHOLESTEROL)	_____	TUMORS	_____
HYPOGLYCEMIA	_____	WARTS (SPECIFY LOCATION)	_____

Do you regularly experience pain: chest, sciatic, abdominal or headaches?

Specify: \_\_\_\_\_

---

**ILLNESSES OR PROBLEMS** Mark an X next to any of the following, which you have had or now have.

- |                        |                            |                         |                          |
|------------------------|----------------------------|-------------------------|--------------------------|
| 1. ___ eye infections  | 9. ___ liver disease       | 17. ___ chicken pox     | 25. ___ mononucleosis    |
| 2. ___ thyroid disease | 10. ___ diverticulosis     | 18. ___ German measles  | 26. ___ venereal disease |
| 3. ___ eczema          | 11. ___ hernia             | 19. ___ scarlet fever   | 27. ___ yellow jaundice  |
| 4. ___ hives or rashes | 12. ___ hemorrhoids        | 20. ___ measles         | 28. ___ other            |
| 5. ___ bronchitis      | 13. ___ neuralgia/neuritis | 21. ___ mumps           | 29. ___ hay fever        |
| 6. ___ emphysema       | 14. ___ tension/anxiety    | 22. ___ polio           | 30. ___ asthma           |
| 7. ___ pneumonia       | 15. ___ depression         | 23. ___ rheumatic fever | 31. ___                  |
| 8. ___ pancreatitis    | 16. ___ hyperactivity      | 24. ___ malaria         | 32. ___                  |

**TESTS & IMMUNIZATIONS** Instructions as above. **MEDICINES** Instructions as above. T=Taking A=Allergic to

- | Year                     | Year                    | T      | A                   | T       | A                  |
|--------------------------|-------------------------|--------|---------------------|---------|--------------------|
| 1. ___ chest x-ray       | 9. ___ smallpox "shots" | 1. ___ | ___ antibiotics     | 9. ___  | ___ blood pressure |
| 2. ___ kidney x-ray      | 10. ___ tetanus "shots" | 2. ___ | ___ penicillin      | 10. ___ | ___ aspirin        |
| 3. ___ G.I. series       | 11. ___ polio "shots"   | 3. ___ | ___ sulfa           | 11. ___ | ___ diet pills     |
| 4. ___ colon x-rays      | 12. ___ typhoid "shots" | 4. ___ | ___ opiates/codeine | 12. ___ | ___ antacids       |
| 5. ___ gallbladder x-ray | 13. ___ flu "shots"     | 5. ___ | ___ diuretics       | 13. ___ | ___ laxatives      |
| 6. ___ electrocardiogram | 14. ___ mumps "shot"    | 6. ___ | ___ sedatives       | 14. ___ | ___ cold tablets   |
| 7. ___ TB test           | 15. ___ measles "shot"  | 7. ___ | ___ stimulants      | 15. ___ | ___ other          |
| 8. ___ sigmoidoscopy     | 16. ___ other           | 8. ___ | ___ Demerol         | 16. ___ | ___ other          |

**MEDICAL HISTORY** Mark an X if the answer is "Yes" and fill in appropriate information as indicated.

- |  |  |
|--|--|
| 1. ___ Are you troubled with painful muscles/joints? | 27. ___ Do little things annoy you?  |
| 2. ___ Are your joints ever swollen?                 | 28. ___ Do work or family problems disturb you?  |
| 3. ___ Are you troubled with back or shoulder pain?  | 29. ___ Are you having any sexual difficulties?  |
| 4. ___ Are your feet painful?                        | 30. ___ Have you ever considered committing suicide?                                       |
| 5. ___ Are you in any way handicapped?               | 31. ___ Have you ever desired psychiatric help?  |
| 6. ___ Do you have skin problems?                    | 32. ___ Have you gained or lost much weight recently?                                      |
| 7. ___ Does your skin itch or burn?                  | 33. ___ Do you tend to be too hot or too cold?   |
| 8. ___ Do small cuts bleed excessively?              | 34. ___ Have you lost interest in eating recently?   |
| 9. ___ Do you bruise easily?                         | 35. ___ Do you always seem hungry?   |
| 10. ___ Do you ever faint or feel faint?             | 36. ___ Are you more thirsty than usual lately?  |
| 11. ___ Is any part of your body numb?               | 37. ___ Is there any swelling of your armpits or groin?                                    |
| 12. ___ Have you ever had seizures or convulsions?   | 38. ___ Are you frequently exhausted or fatigued?  |
| 13. ___ Has your handwriting changed lately?         | 39. ___ Do you have difficulty falling asleep?   |
| 14. ___ Do you tend to shake or tremble?             | 40. ___ Do you exercise less than three times a week?                                      |
| 15. ___ Are you nervous around strangers?            | 41. ___ Do you smoke? How much? _____  |
| 16. ___ Is it hard to make decisions?                | 42. ___ Do you take more than 2 alcoholic drinks a day?                                    |
| 17. ___ Is it hard to concentrate or remember?       | 43. ___ Do you take more than 6 cups of coffee daily?                                      |
| 18. ___ Do you usually feel lonely or depressed?     | 44. ___ Do you use sleeping pills, marijuana, pain pills?                                  |
| 19. ___ Do you cry often?                            | 45. ___ Do you use heroin, cocaine, LSD, PCP, etc?   |
| 20. ___ Do you think you have a hopeless outlook?    | 46. ___ Do you bite your nails?  |
| 21. ___ Do you have difficulty relaxing?             | 47. ___ Do you usually ignore using your seat belt?  |
| 22. ___ Do you tend to worry a lot?                  | 48. ___ Have you visited a country other than the U.S.<br>In the past 6 months? List _____ |
| 23. ___ Do you have frightening dreams or thoughts?  | 49. ___ Are you troubled with heartburn?   |
| 24. ___ Are you overly shy or sensitive?             | 50. ___ Do you feel bloated after eating?  |
| 25. ___ Do you strongly dislike criticism?           | 51. ___ Are you troubled with belching   |

52. \_\_\_\_ Do you have pain in the pit of your stomach?
53. \_\_\_\_ Do you become nauseated easily?
54. \_\_\_\_ Have you ever vomited blood?
55. \_\_\_\_ Is it difficult or painful to swallow?
56. \_\_\_\_ Are you constipated more than twice a month?
57. \_\_\_\_ Are bowel movements loose more than one day?
58. \_\_\_\_ Are bowel movements ever black or bloody?
59. \_\_\_\_ Are bowel movements ever gray in color?
60. \_\_\_\_ Do you have pain when moving your bowels?
61. \_\_\_\_ Have you ever had any bleeding from the rectum?
62. \_\_\_\_ Do you get up at night to urinate frequently?
63. \_\_\_\_ Do you urinate more than 5 or 6 times daily?
64. \_\_\_\_ Do you wet the bed or your pants?
65. \_\_\_\_ Do you have burning or pains on urination?
66. \_\_\_\_ Has your urine been brown, black or bloody?
67. \_\_\_\_ Do you have difficulty starting to urinate?
68. \_\_\_\_ Do you feel the need to urinate constantly?
69. \_\_\_\_ Do you have any mercury ("silver") fillings in your teeth?
70. \_\_\_\_ Do you have root canals in any teeth?
71. \_\_\_\_ Has your sense of taste changed lately?
72. \_\_\_\_ Does your nose drain liquid when you don't have a cold?

**For Men Only** (Number 84 through 88)

73. \_\_\_\_ Is your urine stream weak or slow?
74. \_\_\_\_ Have you been told you have prostate trouble?
75. \_\_\_\_ Do you have burning or discharge from the penis?
76. \_\_\_\_ Are there swellings or lumps on your testicles?
77. \_\_\_\_ Do your testicles become painful at times?

**For Women Only** (Number 89 through 106)

78. \_\_\_\_ Do you have menstrual trouble?
79. \_\_\_\_ Do you have breakthrough bleeding?
80. \_\_\_\_ Do you have heavy menstrual bleeding?
81. \_\_\_\_ Do you have bleeding after intercourse?
82. \_\_\_\_ Are you troubled with pre-menstrual tension?
83. \_\_\_\_ Do you have hot flashes often?
84. \_\_\_\_ Are you taking birth control pills?
85. \_\_\_\_ Have you had lumps in your breasts?
86. \_\_\_\_ Are you troubled with a vaginal discharge?
87. \_\_\_\_ / \_\_\_\_/20 \_\_\_\_ Date of last PAP smear.
88. \_\_\_\_ / \_\_\_\_/20 \_\_\_\_ Date of last period.
89. \_\_\_\_ Number of pregnancies.
90. \_\_\_\_ Number of miscarriages.
91. \_\_\_\_ Number of abortions, if any.
92. \_\_\_\_ Number of stillbirths.
93. \_\_\_\_ Number of premature births.
94. \_\_\_\_ Number of children born alive.
95. \_\_\_\_ Number of cesarean births.

96. \_\_\_\_ Do you have colds more than every 2 months?
97. \_\_\_\_ Is your throat sore when you don't have a cold?
98. \_\_\_\_ Has your voice been hoarse when you didn't have a cold?
99. \_\_\_\_ Are you bothered with coughing spells?
100. \_\_\_\_ Have you ever coughed up blood?
101. \_\_\_\_ Do you sweat a lot or have night sweats?
102. \_\_\_\_ Are you troubled with thumping/racing heart?
103. \_\_\_\_ Do you have dizziness or lightheadedness?
104. \_\_\_\_ Do you wake up at night short of breath?
105. \_\_\_\_ Do you ever have swollen feet or ankles?
106. \_\_\_\_ Have you ever been told you have a heart murmur?
107. \_\_\_\_ Do you have headaches more than once a week?
108. \_\_\_\_ Does twisting your neck cause pain?
109. \_\_\_\_ Have you ever had lumps/swelling in the neck?
110. \_\_\_\_ Do you wear glasses?
111. \_\_\_\_ Does your eyesight ever blur?
112. \_\_\_\_ Does your eyesight seem to be getting worse?
113. \_\_\_\_ Do you ever see double?
114. \_\_\_\_ Do you see colored halos around lights?
115. \_\_\_\_ Do you have pain or itching around your eyes?
116. \_\_\_\_ Do your eyes blink water most of the time?
117. \_\_\_\_ Have you had trouble with your eyes recently?
118. \_\_\_\_ Do you have difficulty hearing?
119. \_\_\_\_ Have you had earaches lately?
120. \_\_\_\_ Have you had liquid running from your ears lately?
121. \_\_\_\_ Do you have constant noise in your ears?
122. \_\_\_\_ Do you get motion sickness in a car or plane?
123. \_\_\_\_ Do you have any problems with your teeth?
124. \_\_\_\_ Do you have sore swellings of your gums or jaws?
125. \_\_\_\_ Is your tongue sore or sensitive?
126. \_\_\_\_ Is your nose stuffed up when you don't have a cold?
127. \_\_\_\_ Do you have sneezing spells?
128. \_\_\_\_ Does your nose bleed for no reason?
129. \_\_\_\_ Have you been told you have enlarged tonsils?
130. \_\_\_\_ Do you wheeze or have to gasp for breath?
131. \_\_\_\_ Do you cough up a lot of phlegm?
132. \_\_\_\_ Do you get chest colds more than once a month?
133. \_\_\_\_ Do you have high blood pressure?
134. \_\_\_\_ Do you get pains or tightness in the chest?
135. \_\_\_\_ Do you become short of breath easily?
136. \_\_\_\_ Do you use more pillows to help you breathe at night?
137. \_\_\_\_ Do you get cramps in your legs or feet at night?

# PAYMENT POLICY

All charges are to be paid when services are rendered. We will provide you with the necessary forms to file with your insurance company. However, we do not process insurance forms or collect from insurance companies. Please be informed that Medicare may not reimburse you for our services.

We accept the following:

- Cash
- Traveler's checks, money orders or cashier's checks
- Visa or MasterCard
- Check with current driver's license and another form of identification (I.D.)

SHOULD YOU DECIDE TO PAY BY CHECK OR CREDIT CARD, THE FOLLOWING INFORMATION WILL MAKE YOUR FIRST VISIT SMOOTHER:

RESPONSIBLE PARTY NAME \_\_\_\_\_

BANK NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

BANK ADDRESS \_\_\_\_\_

CHECKING ACCOUNT # \_\_\_\_\_

VISA CARD # \_\_\_\_\_ EXP. DATE \_\_\_\_\_

MASTERCARD # \_\_\_\_\_ EXP. DATE \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ STATE \_\_\_\_\_

## PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN ACKNOWLEDGEMENT

I understand the above payment policy of The Nevada Clinic, and am aware that failure to comply with the above stated policy may result in collection actions and/or termination of future services.

\_\_\_\_\_  
RESPONSIBLE PARTY

\_\_\_\_\_  
DATE