New patient health history
General information

Name ______________________________________ ☐ female ☐ male Birthdate________Age_____

Address ________________________________City ______________ State ______ Zip ___________

Telephone (home) __________________ (work)______________________(cell)__________________

Email address ______________________
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Living situation: ☐ alone ☐ friends ☐ partner ☐ spouse ☐ parents Number of children ___________

Occupation ______________________________ Employer _________________________________

Employer address ____
Employment status: ☐ full-time ☐ part-time ☐ school ☐ retired ☐ unemployed other ___________

Name of Partner/Spouse/Parent: ____
Circle one

Emergency contact ______________________________ Relationship __________________________

Address ____ Telephone _____________

How did you hear about us? Phone book_____ Insurance _____ Other ____________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

I herby authorize the release of any medical information necessary to in the processing of my medical claim. I also authorize payment directly to HealthMax for the medical benefits.

I authorize my practitioner to examine and treat me, to consult with another healthcare practitioner in regards to continuing my care.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed ____ Date ______________
Patient, parent or guardian of minor

In your opinion, what are your most important physical, emotional, or mental health problems? Indicate which is/are of the most immediate concern to you.

1. ______
2. ______
3. ______
4. ______
5. ______

How do you rate your overall health? Excellent Good Fair Poor

What are your expectations for today's visit? ______

______

What are your expectations for our work together in general? ______

______

Hospitalizations

What hospitalizations or surgeries have you had? When did they occur? ______

______

Special studies

What diagnostic imaging studies have you had? (i.e. X-rays, CT scan, mammogram, MRI, bone density scan, EKG. EEG) ______

______

______

Blood work

Date of last blood test? ______ What tests did you have(if known) ______

Childhood Illnesses

Rubella (german, 3 day measles) ______

Whooping cough ______

Rheumatic Fever ______

Scarlet Fever ______

Measles (two week) ______

Chicken pox ______

Asthma ______

Diphtheria ______

Roseola ______

Mumps ______

Polio ______

Immunizations

Polio Y N

Tetanus Y N

Measles/Mumps/Rubella (MMR) Y N

Pertussis Y N

Diphtheria Y N

Other ______

Your health history

Now	Past	Never		Now	Past	Never	
_____	_____	_____	Allergies	_____	_____	_____	Heart Murmur*
_____	_____	_____	Anemia	_____	_____	_____	High Blood Pressure
_____	_____	_____	Arthritis	_____	_____	_____	Injury (serious)
_____	_____	_____	Asthma	_____	_____	_____	Kidney Disease
_____	_____	_____	Alcoholism	_____	_____	_____	Liver Disease
_____	_____	_____	Bleeding problem	_____	_____	_____	Overweight
_____	_____	_____	Cancer	_____	_____	_____	Pneumonia
_____	_____	_____	Candida(yeast)	_____	_____	_____	Polio
_____	_____	_____	Colitis	_____	_____	_____	Rheumatism
_____	_____	_____	Drugs/Alcohol use*	_____	_____	_____	Thyroid Problem
_____	_____	_____	Eczema	_____	_____	_____	Tuberculosis
_____	_____	_____	Emphysema	_____	_____	_____	Sexually Trans. Disease
_____	_____	_____	Headache	_____	_____	_____	Others*

*Please specify ____

Family history

Please list the ages of your family members and any medical problems they have had. If deceased, please list age of death and cause.

Mother's side
Grandfather ______________________________
Grandmother ______________________________
Mother ______________________________

Father's side
Grandfather ______________________________
Grandmother ______________________________
Father ______________________________

Sisters ____
Brothers ____

Are there any stories in your life history that would help you and I to work together better?

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____
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