PATIENT INFORMATION

REFERRED BY_____

PATIENT NAME:_____DATE OF BIRTH:_____

ADDRESS:_____ APT#:_____

CITY, STATE, ZIP:_____ EMAIL:_____

HOME #:_____ CELL #:_____

MARITAL STATUS: S M W SPOUSE'S NAME:_____ SSN:_____

EMPLOYER:_____ ADDRESS:_____

CITY, STATE,ZIP:_____ WORK#:_____

PRIMARY INSURANCE:_____

SUBSCRIBER NAME:_____ DATE OF BIRTH:_____

ID #:_____ GROUP #:_____

SECONDARY INSURANCE:_____

SUBSCRIBER:_____ DATE OF BIRTH:_____

ID#:_____ GROUP #:_____

EMERGENCY CONTACT:_____ PHONE#:_____

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE ALL PAYMENTS DIRECTLY TO KUSHNER WELLNESS CENTER FOR MY MEDICAL AND SURGICAL EXPENSE OTHERWISE PAYABLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY. ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. CANCELLATIONS NOT MADE AT LEAST 24 HOURS IN ADVANCE ARE SUBJECT TO A CANCELLATION CHARGE.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

KUSHNER WELLNESS CENTER

PHONE (562) 528-9792 FAX: (323)225-9886

PATIENT INFORMATION

(All information is strictly confidential)

Name:_____ **Age:**_____ **Date:**_____

Are there any specific medical concerns you would like to discuss today?_____

PAST MEDICAL HISTORY

Birthplace. Where were you born? _____

Immunizations. Have you completed the following (circle: **Y="Yes"; N="No"; ?="Don't Know"**)

Tetanus Shot within the past 10 years.. **Y N?**
Pneumovax (pneumonia vaccine)..... **Y N?**
Hepatitis A (series of 2 immunizations) **Y N?**
Hepatitis B (series of 3 immunizations) **Y N?**

Infections. Have you ever had any of the following:

Measles, Mumps, or Rubella..... **Y N?**
Chickenpox, or the varicella vaccine to Prevent chickenpox..... **Y N?**
Scarlet fever..... **Y N?**
Rheumatic fever..... **Y N?**
Diphtheria..... **Y N?**
Tuberculosis, or positive PPD test..... **Y N?**
Hepatitis A, B, or C..... **Y N?**
Poliomyelitis..... **Y N?**

Medical Conditions Check (√) if you have recently (over the past year, or since your last physical exam with us) been diagnosed with any of the following:

( ) Heart Disease (Coronary Artery Disease)
( ) Congestive Heart Failure
( ) Stroke (Cerebrovascular Accident)
( ) Irregular Heartbeat (Arrhythmia)
( ) High Blood Pressure (Hypertension)
( ) High Cholesterol (Hyperlipidemia)
( ) Chest Pain for a different reason than above
( ) Asthma
( ) Emphysema or COPD
( ) Diabetes Mellitus
( ) Thyroid Disease
( ) Arthritis
( ) Osteoporosis
( ) Anemia
( ) Allergic Rhinitis (Hayfever)
( ) Heartburn (Acid Reflux)
( ) Ulcer Disease
( ) Melanoma
( ) Breast Cancer
( ) Colon Cancer
( ) Other Cancer_____
( ) Blood Clotting Disorder
( ) Kidney Disease or Kidney Stones
( ) Liver Disease
( ) Seizures (Epilepsy)
( ) Lupus, or any other Autoimmune Disease
( ) Other _____
( ) Other_____

Past hospitalizations. Please list previous hospitalizations and surgeries, as well as the approximate date (year) the event occurred.

Year	Reason for Hospitalization	Month/Year	Reason for Hospitalization

Have you ever needed a blood transfusion? **Y N** What year?_____
Have you ever been treated for: Fractures? **Y N** If yes, where and when?_____
Head Injury? **Y N** If yes, when?_____

MEDICATIONS List medications you are currently taking, along with dosage and frequency. Please include over the counter medications, vitamins, and herbal supplements if any are taken regularly.

ALLERGIES

List any allergies to medications:

_____ _____ _____

_____ _____ _____

Allergies to Food:

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Are you: SINGLE MARRIED DIVORCE WIDOWED ALTERNATIVE LIFE STYLE (circle)

Occupation_____ Hours worked per day_____ Number of days per week_____

Do you smoke cigarettes? Y N How many a day? _____ For how many years? _____

Do you drink alcohol? Y N How much on average?_____ drinks per DAY WEEK MONTH YEAR

Have you ever been arrested for drinking and driving? Y N

Do you drink coffee or caffeinated products? Y N How many cups/ sodas per day? _____

Have you ever used any illicit drugs (e.g., cocaine, marijuana, heroin, LSD, ecstacy, etc/) ? Y N

Do you exercise regularly? Y N # of times a week_____ Activity_____

Are you on any special diet (e.g., low cholesterol, vegetarian, etc.,)? _____

FAMILY HISTORY

	AGE(S) IF STILL LIVING	AGE(S) IF DECEASED	CAUSE OF DEATH	MAJOR MEDICAL CONDITIONS
MOTHER				
FATHER				
SISTER (S)				
BROTHER (S)				
CHILDREN				

Check ( ) if there is a family history of any of the following and list the relationship(s) to you:

( ) HIGH BLOOD PRESSURE _____

( ) HEART DISEASE _____

( ) HIGH CHOLESTEROL _____

( ) STROKES _____

( ) DIABETES _____

( ) KIDNEY DISEASE _____

( ) THYROID DISEASE _____

( ) EPILEPSY _____

( ) OSTEOPOROSIS (relatives who have broken hips or lost height) _____

( ) BREAST CANCER _____

( ) COLON CANCER _____

( ) MELANOMA _____

( ) OTHER CANCER _____

( ) TUBERCULOSIS _____

( ) ARTHRITIS _____

( ) OTHER _____

REVIEW OR SYSTEMS

EYES, EARS, NOSE, THROAT

Y N I am hard of hearing.
Y N I have constant noises in my ears
Y N I often have a bad draining ear or earaches
Y N I have had bad nosebleeds or a constantly runny nose at times
Y N My vision is poor
Y N I often see spots before my eyes
Y N I have been totally or partially blind in the past
Y N I suffer from frequent sore throats
Y N I have had a goiter or thyroid disease in the past
Y N I often feel a choking lump in my throat
Y N I frequently suffer from heavy chest colds

RESPIRATORY

Y N I suffer from asthma
Y N I am troubled by constant coughing
Y N I have coughed up blood or pus in the past
Y N I sometimes have severe soaking swears or fevers
Y N I have a history of tuberculosis
Y N I have had a chronic chest condition in the past
Y N I often have pain in my chest when taking deep breaths
Y N I am told I snore

CARDIOVASCULAR

Y N I have been told I have heart trouble in the past
Y N I get chest pains
Y N I have woken up in the night completely out of breath
Y N I am often bothered by thumping of my heart or a racing heartbeat, or an irregular heartbeat
Y N I have been told by my doctor that my blood pressure was too low
Y N I have a history of congestive heart failure
Y N I need to sleep on more than one pillow to feel comfortable
Y N At times, I need to sit up to catch my breath
Y N I often need to stop for breath when walking up stairs
Y N I have been told by my doctor I have varicose veins
Y N I suffer from frequent leg cramps when I walk

GASTROINTESTINAL

Y N I have had unexplained weight loss recently
Y N My appetite is poor
Y N I usually feel bloated after eating
Y N I frequently suffer from indigestion, heartburn, or acid reflux symptoms (If answer is YES, was any testing doneY/N)
Y N My doctor has told me I have a history of a stomach ulcer.
Y N I usually pass a lot of gas by rectum
Y N I frequently have problems with diarrhea
Y N I frequently have problems with constipation
Y N I suffer from frequent stomach or abdominal pain
Y N I have vomited blood in the past
Y N I have passed blood with my bowel movements in the past
Y N I have had a black, sticky, tarry bowel movement in the past
Y N I have had a white chalky-colored bowel movement in the past
Y N Recently, my bowel movement have changed in either pattern or consistency.
Y N I have had my eyes and skin turn yellow in the past, or I have a history of hepatitis or exposure to hepatitis

Y N I need to urinate very frequently (If Yes, please estimate number of times during the day:____)
Y N I have trouble holding my urine.
Y N I have in the past dribbled urine during sneezing, coughing or laughing.
Y N I have history or pus, sugar or protein in my urine.
Y N I have a history of blood in my urine.
Y N I regularly get up in the middle of the night to urinate. (If Yes, how many time a night?_____)
Y N I often have pain or burning during urination
Y N It takes me a long time to complete my urination
Y N I have had kidney disease in the past
Y N I have trouble starting my stream when I urinate
Y N Sexual relations are painful or difficult for me
Y N Recently, I have lost interest in sexual relations

****SKIN AND EXTREMITIES****

Y N I have morning joint stiffness
Y N I have a history of arthritis or rheumatism
Y N My joints are often painful or swollen (If Yes, which ones?_____)
Y N I frequently get severe leg cramps when walking
Y N I have skin rashes
Y N I have recently noticed a changing mole or bump on my body

****NEUROMUSCULAR****

Y N I suffer from frequent severe headaches
Y N I have numbness or tingling in one or more parts of my body
Y N I have weakness in one or more parts of my body
Y N I have trouble falling asleep, or I wake up often in the middle of the night
Y N I wake up tired
Y N I have problems with pain in my muscles, or my muscles are frequently very sore
Y N I have frequent problems with leg cramps at night
Y N My legs feel restless when I try to sleep and I keep feeling like I need to move them around in the bed
Y N I have problems with my balance, or I fall frequently
Y N I have episodes where I feel as if I'm spinning around, or the room is spinning even though I'm not moving
Y N I have had broken bones in the past
Y N I am constantly tired or exhausted
Y N I become seriously depressed at times, or feel unhappy and unwanted
Y N I have considered suicide in the past
Y N I feel anxious or nervous most of the time
Y N I have had panic attacks in the past

****HEMATOLOGY/ONCOLOGY****

Y N I bruise more easily than normal, or bleed excessively when I cut myself
Y N I have a history of anemia (low blood count)
Y N I consider myself at high risk for AIDS
Y N I have a history of cancer

****ENDOCRINE****

Y N I have a history of thyroid trouble in the past, or I have taken thyroid medications in the past
Y N I have marked difficulty managing in hot or cold weather
Y N I am often extremely thirsty
Y N I have had problems with high blood sugars in the past, or a history of diabetes

*****FOR WOMEN ONLY*****

How old were you when you first started menstruating?____ Date of Last Menstrual Period_____
Total # or pregnancies_____ # of children living _____ # of children deceased_____ # of miscarriages_____

Y N My periods are usually regular (about once a month)
Y N I have an excessive amount of bleeding with my periods
Y N I frequently have pain/cramps with my periods
Y N I have had a frequent abnormal vaginal discharge, or an odor in my vaginal area
Y N I have vaginal burning and itching
Y N I have had a breast lump in the past, or discharge from my nipples
Y N I get moody before my periods begin