Medical Center Plus

1685 E Univsersity Dr. Suite E, Auburn, AL 36830

Patient Name_____ Date: _____

Email: _____

SS #/SIN_____ DOB_____ ☐ Male ☐Female

Home phone_____ Cell Phone _____

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address _____City _____ State_____

Zip_____

Employer Name:

_____

Spouse or Patient's Guardian name_____

Spouse's Employer_____

Whom may we thank for referring you?

_____

Person to contact in case of an emergency_____

Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Parent or Guardian signature _____ Date _____

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient

_____

Address _____Home Phone

_____

E-Mail _____Cell Phone

_____

Driver's License # _____ Date of Birth:

_____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____

Zip_____

Insurance Company_____ Group #_____ Union or local #

_____

Ins. Co. Address _____ City _____ State _____

Zip_____

Chief Complaint: _____

History of Present illness:

Location: _____ **Quality:** _____

(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity: _____ **Duration:** _____

(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?) (How long have you had this pain/ problem? When did it start?)

Timing: _____ **Context:** _____

(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ **Modifying Factors** _____

_____ _____

(What other associated problems have you been having?) (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles……	NO YES	Anemia……..NO	YES	Back Trouble……NO	YES	Hepatitis……NO	YES
Mumps……	NO YES	Bladder Infection…….NO	YES	High Blood Pressure……NO	YES	Ulcer……NO	YES
Chicken Pox……	NO YES	Epilepsy……NO	YES	Low Blood Pressure…….NO	YES	Kidney Disease……NO	YES
Whooping Cough…	NO YES	Migraine Headaches. NO	YES	Hemorrhoids……NO	YES	Thyroid Disease……NO	YES
Scarlet Fever……	NO YES	Tuberculosis……..NO	YES	Date of Last Chest X-Ray_____		Bleeding Tendency…….NO	YES
Diphtheria……	NO YES	Diabetes……..NO	YES	Asthma……NO	YES	Any Other Disease…….NO	YES
Small pox……	NO YES	Cancer……NO	YES	Hives of Eczema……NO	YES	(Please List):	
Pneumonia……	NO YES	Polio……NO	YES	AIDS & HIV……NO	YES		
Rheumatic Fever…	NO YES	Glaucoma……NO	YES	Infectious Mono……NO	YES	_____	
Arthritis……	NO YES	Hernia……NO	YES	Bronchitis……NO	YES		
Venereal Disease…	NO YES	Blood or Plasma Transfusion……..NO	YES	Mitral Valve Prolepses….NO	YES	_____	
				Stroke……NO	YES		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication: (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			
Excessive Exposure					
At home or at work to:	Fumes: _____	Dust: _____	Solvents: _____	Airborne Particles: _____	Noise: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

PATIENT NAME: _____ **DATE:**_____

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Name:_____ DOB _____ Date:_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date