PATIENT INFORMATION (PLEASE PRINT AND COMPLETE ALL INFORMATION)

Last Name ____________________ First Name____________________ Middle Name____________

Mailing Address__________________________ City _________________ State _____ Zip ____________

Home Phone _______________ Cell Phone _____________ Date of Birth __________ Age ______

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow ☐ Separated Sex: ☐ M ☐ F

Patient's Place of Employment ____________________ Work Phone _________________

How did you hear about us? ☐Billboard ☐Street Sign ☐ Website ☐Print Ad *if so, where?* _________________

☐Employer ☐ Friend/Family ☐Facebook ☐ Other ____________________

E-mail Address ____

I provide my express consent to receive automated text, email, and voice messages at the phone number and/or address above. ☐ Yes ☐ No

FAMILY INFORMATION

Spouse's Name ____________________ Guardian's Name (if patient is child)_________________________

Spouse's/Parent's Place of Employment ____________________ Work Phone ______________________

Please list the name of a relative or friend that we can reach in case of an emergency:

Name ______________________ Relationship ______________________ Phone ____________________

RELEASE OF INFORMATION

I authorize that I have reviewed a copy of the HIPAA (Health Insurance Portability and Accountability Act) and agree to the release of pertinent medical information to insurance carriers and other physicians for payment and treatment.

Signature of Patient (or Patient's Representative, if patient is unable to sign or is a minor) Date Relationship

Patient's Name ______________________________ Date ____________________

Patient History - Current or Recurring problems

Please check if you currently have or have had any of the following:

Genitourinary	*Respiratory*	*Cardiovascular*	*Neurological*	*Gastrointestinal*
☐ Frequency with urine	☐ Cough	☐ Chest pain	☐ Fainting	☐ Constipation
☐ Burning with urine	☐ Shortness of breath	☐ Ankle swelling	☐ Seizures	☐ Diarrhea
☐ Bloody urine	☐ Asthma	☐ High blood pressure	☐ Dizziness/Vertigo	☐ Blood in stool
☐ Prostate problems	☐ Emphysema/COPD	☐ Heart murmur	☐ Headaches/Migraines	☐ Ulcers
☐ Erectile dysfunction	☐ Sleep apnea	☐ Irregular heart beat	☐ Depression/Anxiety	☐ Heartburn
☐ Kidney/Bladder problems		☐ Heart attack	☐ Psychiatric disorder	

Musculoskeletal	*Endocrine*	*HEENT*	*Other*		
☐ Joint pain / swelling	☐ Diabetes	☐ Hayfever / Allergies	☐ Anemia	☐ Hepatitis	☐ Other:
☐ Neck pain	☐ Thyroid problems	☐ Vision problems	☐ Cancer	☐ Liver problems	___________
☐ Back pain	☐ Osteoperosis				
☐ Gout					
☐ Arthritis					

Medications:

List all current prescription and over-the-counter medications you are taking. Please include vitamins and herbal supplements.

Check if you are not taking medication. ☐

Name	Dose	Reason

Allergies:

List all food and medication allergies.

Check if you do not have any allergies. ☐

____

____

____

Latex allergy? ☐Y☐N

Date of Last Preventative:

Colonoscopy: Year _____ Normal?: ☐Y☐N

Pap: Year _____ Normal?: ☐Y☐N

Mammograms: Year _____ Normal?: ☐Y☐N

Bone Density: Year _____ Normal?: ☐Y☐N

Physical: Year _____

Bloodwork: Year _____

PSA: Year _____

EKG: Year _____

Vaccines:

Tetanus: Year _____

TB: Year _____ Positive: ☐Y ☐N

Flu: Year _____

Pneumonia: Year _____

Past Surgical History

Description	*Date*

Family History:

Please check medical problems ***immediate family members*** have or have had in the past.

Medical Complaints	Relationship
☐ Diabetes	__________
☐ Hypertension (High blood pressure)	__________
☐ Cancer / Type: ____________	__________
☐ High Cholesterol	__________
☐ Thyroid Disease	__________
☐ Heart Disease	__________

Social History

Do you smoke or use tobacco? ☐Y☐N

If yes, how many packs/day? ______

Do you drink alcohol? ☐Y☐N

If yes, how many drinks/week? ______

Do you use recreational drugs? ☐Y☐N

Do you exercise? ☐Y☐N

If yes, how many times/week? ______

Have you ever been a victim of violence? ☐Y☐N

Have you had HIV or STD's? ☐Y☐N

Females Only

Date of last menstrual period: ____________

Current method of birth control: ____________

Total # of pregnancies: ____________

# of Live Births: ____________

Miscarriages: ____________

Abortions: ____________

ProHealth
Medical Care

CONSENT FORM

Name: ______________________________ Date of Birth: ________________ Age: ______ Sex: M F

CONSENT FOR TREATMENT: RELEASE OF MEDICAL INFORMATION & FINANCIAL RESPONSIBILITY

I, the undersigned, consent to treatment of the above named patient. I hereby authorize the release of any and/or all medical records to the referring physician, or those involved in the payment of the account. I further acknowledge full financial responsibility for any services rendered by ProHealth Medical Care, and understand that payment of charges incurred is due at the time of service.

Date: ___________________ Signed: ____

If patient is a child, guardian's signature is required

MEDICAL INFORMATION DISCLOSURE

I do hereby authorize that medical information about myself may be disclosed to the person or persons listed below. This includes current or past treatments, medication information, the discussion of any lab or x-ray results, consultation reports from any referring physicians, and in-patient information. I also authorize said person or persons to make payments on my behalf, to obtain prescriptions in my name in the event I am not present, and accept on my behalf any sample medication that might be offered as a courtesy to me. This designated person (or persons so named) may have the right to verify an appointment or make an appointment on my behalf. I do further absolve the staff of ProHealth Medical Care of any breach of confidentiality regarding my medical records and my privacy.

Release to: _________________________________ Relationship: ______________

Signed: _____________________________________ Date: _________________

If patient is a child, guardian's signature is required

For Parents or Guardians of Minors only

IF THE PATIENT IS A DEPENDENT CHILD, THIS INFORMATION MUST BE PROVIDED

Guarantor: _______________________________________ Relationship: __________________

Phone Home: ___________________ Work: ___________________ Cell: ___________________