

Medical History Form

Patient _____ Date of Birth _____
First Name Middle Initial Last Name

Allergies _____ Drug Allergies _____

Reason for Visit _____

Occupation _____

Medications: List all medications you are currently taking, prescribed and over the counter, including frequency and dosage amount.

| Medications | Dosage | Frequency |
|-------------|--------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

| Medications | Dosage | Frequency |
|-------------|--------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

Family History: From the list, check any conditions that may apply to your family history.

| Family History | YES | NO |
|------------------------|-----|----|
| Heart Disease | | |
| High Blood Pressure | | |
| Stroke | | |
| Cancer | | |
| Glaucoma | | |
| Diabetes | | |
| Epilepsy / Convulsions | | |

| | YES | NO |
|---------------------|-----|----|
| Bleeding Disorder | | |
| Kidney Disease | | |
| Thyroid Disease | | |
| Mental Illness | | |
| Osteoporosis | | |
| Psoriasis | | |
| Autoimmune Disorder | | |

Hospitalizations: List hospitalizations for operations or serious illnesses (excluding pregnancy)

| Year | Reason |
|------|--------|
| | |
| | |
| | |

| Year | Reason |
|------|--------|
| | |
| | |
| | |

Social History:

| Do you: | YES | NO |
|-------------------------|-----|----|
| Smoke | | |
| Packs daily? _____ | | |
| # Years? _____ | | |
| Interested in stopping? | | |
| Drink alcohol | | |
| How much? _____ | | |
| Type _____ | | |
| Drug Abuse | | |
| How much? _____ | | |
| Type _____ | | |

| Women only: | YES | NO |
|-----------------------------|-----|----|
| Are you pregnant? | | |
| Are you planning pregnancy? | | |

| | YES | NO |
|----------------------------|-----|----|
| Do you have a living will? | | |

List Hospital Preference:

List Pharmacy Preference:

Past Medical History: From the following list, please check any symptoms or conditions that apply to you.

| Skin | YES | NO |
|------------------------------------|------------|-----------|
| Rashes, psoriasis or dermatitis | | |
| New skin growth or mole | | |
| History of skin cancer | | |
| When? Where? | | |
| | | |
| Eyes | YES | NO |
| Permanent blindness in either eye | | |
| Cataracts | | |
| Glaucoma | | |
| | | |
| Ears / Nose / Throat | YES | NO |
| Loss of Hearing | | |
| Hearing aids? | | |
| ringing in the ears | | |
| Attacks of vertigo (dizziness) | | |
| Frequent sinus infections | | |
| Frequent sore throat | | |
| Sleep apnea | | |
| Difficulty in swallowing | | |
| Frequent headache | | |
| Nose bleeds | | |
| | | |
| Respiratory | YES | NO |
| Asthma or wheezing | | |
| Recent bronchitis or chest cold | | |
| Coughing up blood | | |
| Shortness of breath | | |
| | | |
| Stomach / Intestines | YES | NO |
| Stomach ulcer or peptic ulcer | | |
| Frequent heartburn or indigestion | | |
| Hiatal hernia and or acid reflux | | |
| Poor appetite | | |
| Gall bladder attacks | | |
| Frequent diarrhea | | |
| Chronic constipation | | |
| Bright blood from bowels or rectum | | |
| Dark, tarry stools | | |
| Liver disease or jaundice | | |
| | | |
| Blood | YES | NO |
| Bleeding or bruising tendency | | |
| Previous blood transfusion | | |
| History of Hepatitis | | |
| | | |

| Heart & Circulation | YES | NO |
|---------------------------------------|------------|-----------|
| Heart attack | | |
| Hypertension (high blood pressure) | | |
| Heart murmur | | |
| Chest discomfort (angina) with | | |
| physical activity | | |
| Heart failure or fluid in the lungs | | |
| Palpitations, racing or pounding | | |
| heart beat | | |
| Stroke | | |
| Blood clot in artery or vein | | |
| "Mini strokes" or TIA's | | |
| "Black out spells" | | |
| Aneurysm of any blood vessel | | |
| Frequent ankle swelling at bedtime | | |
| Heart surgery | | |
| High cholesterol | | |
| | | |
| Muscles / Bones / Joints | YES | NO |
| Arthritis or other joint disease | | |
| Chronic back trouble | | |
| Bone or joint surgery in past year | | |
| | | |
| Nervous System | YES | NO |
| Migraine headaches | | |
| Epilepsy or seizures | | |
| Date of last seizure? | | |
| Depression | | |
| | | |
| Endocrine / Metabolism | YES | NO |
| Thyroid Disorder | | |
| Recent weight gain or loss (>10 lbs.) | | |
| Diabetes | | |
| | | |
| Kidneys / Urinary Tract | YES | NO |
| Kidney disease or failure | | |
| Kidney stones or infection | | |
| Pain or burning with urination | | |
| Bladder infections during past year | | |
| Blood in urine during past year | | |
| Prostate disease | | |
| | | |
| Reproductive (Women only) | YES | NO |
| Are you or might you be pregnant? | | |
| | | |
| | | |

James C. Wasson, M.D., P.C.

Patient Registration Form

Please fill this form out completely. We will be unable to file your insurance claim without all of this information.

Patient _____ Age _____ Date of Birth _____
First Name Middle Initial Last Name

Address _____
Street City/State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

SS# _____ - _____ - _____ Sex: Male Female

Patient Employer _____ Insured Employer _____

Marital Status: Single Married Divorced Widowed Separated **Military?** Active Retired

If married, spouse's name _____

Children's names and ages _____

Primary Insurance Company _____ HMO PPO Other

Policy Number _____ Group Number _____

Policy Holder: Self Spouse Parent **If policy holder is spouse or parent we need the following:**

Name _____ SS# _____ - _____ - _____ Date of Birth _____

Secondary Insurance Company _____ HMO PPO Other

Policy Number _____ Group Number _____

Policy Holder: Self Spouse Parent **If policy holder is spouse or parent we need the following:**

Name _____ SS# _____ - _____ - _____ Date of Birth _____

Emergency Contact _____

| Name | Relationship | Phone Number |
|----------------------------------|--------------|--------------|
| How did you hear about us? _____ | | |

| | | |
|--|--------------------|------------|
| Release of Medical Information: I authorize the release of any medical information necessary for care or treatment or to process an insurance claim. | Signed _____ | Date _____ |
| | Printed Name _____ | |
| Responsibility for Payments and Assignment: My insurance is a contract between the insurance company and myself. I understand that I have full financial responsibility for all professional services rendered. I agree to remit appropriate co-payments or charges at time of service. I hereby authorize my insurance benefits to be paid directly to James C. Wasson, M.D., P.C. | Signed _____ | Date _____ |
| | Printed Name _____ | |
| | Printed Name _____ | |
| Treatment of a Minor: I, the undersigned parent or legal guardian of the above listed minor, do hereby authorize James C. Wasson, M.D. and his staff to perform any medical or surgical care or treatment which is deemed advisable, in the office or hospital. This consent shall remain in effect until legal age, unless revoked in writing. | Signed _____ | Date _____ |
| | Printed Name _____ | |
| | Printed Name _____ | |

Communication Consent

It is the office policy of James C. Wasson M.D., P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone, and /or pager. Also, faxing patient information to your work place is prohibited. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize James C. Wasson, M.D., P.C. and /or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

| | YES | NO |
|---|-----|----|
| Home Telephone | | |
| Answering Machine | | |
| Work Telephone | | |
| Voice Mail | | |
| Cell Phone and/or Voice Mail | | |
| Pager | | |
| Fax medical records for referrals to another doctor's office | | |

If you would like to have information released to someone other than yourself please complete the following:

Please list names of authorized people:

Spouse: _____ ___ YES ___ NO

Parent: _____ ___ YES ___ NO

Other names (please list relationship such as boyfriend, fiancé,
Girlfriend, sister etc.) _____ ___ YES ___ NO

Printed Name _____

Patient/Guardian Signature: _____

Date: _____