Personal Medical History

***Patient: _____Date of Birth*: _____Today's Date_____**

Patient's Initials _____

Do you now have or have you in the past year any of the following?

General Symptoms	***Muscles & Joints***	***Respiratory***	***Bladder / Urinary***
Y N Change in Appetite	Y N Backache	Y N Chest Pain	Y N Blood in Urine
Y N Depression	Y N Enlarged veins	Y N Chronic cough	Y N Difficulty to start urine
Y N Anxiety	Y N Joint pain or stiffness	Y N Palpitations/fluttering	Y N Frequent urination
Y N Bipolar	Y N Leg cramps when walking	Y N Shortness of breath	Y N Increase in thirst
Y N Dizziness / Fainting	Y N Poor coordination	Y N Spitting blood	Y N Painful urination
Y N Lack of sex drive	Y N Swelling of feet or ankle	Y N Wheezing	Y N Yellowing of skin
Y N Discharge	Last Bone Density?	Date of last chest x-ray?	***Women only***
Y N Memory Loss	***Ear/Eyes/Nose/Throat***	***Gastrointestinal***	Date of last period?
Y N Hot flashes	Y N Dim vision	Y N Chronic Constipation	Date of last pelvic exam?
Y N Recent weight change	Y N Cataracts	Y N Chronic Diarrhea	Date of last mammogram?
Y N Seizures	Y N Glaucoma	Y N Coughing blood	# of pregnancies?
Y N Sensitivity to cold/heat	Y N Do you wear correction?	Y N Difficulty swallowing	# of births?
Y N Sleeplessness	Y N Decreased hearing	Y N Blood ins stool	Y N Take birth control?
Y N Tire easily or weak	Y N Ringing in ears	Y N Heartburn	If yes, what type?
Skin or Allergies	Y N Frequent nose bleeds	Y N Hemorrhoids	***Men only***
Y N Skin changes	Y N Sinus trouble	Y N Nausea	Y N Penis Discharge
Y N Bleeding/bruising	Last eye exam?	Y N Vomiting	Y N Testicle pain or lump
Y N Non healing wounds or sores		Last Colonoscopy? Date:	Y N Impotence

Do you have or have you ever been told you have any of the following?

Y N Alcohol Abuse	Y N Tuberculosis (TB)	Y N Hemophilia	Y N Tonsillitis
Y N Anemia	Y N Colitis	Y N Hepatitis	Y N Migraine Headaches
Y N Arthritis	Y N Shingles	Y N Herpes	Y N Mumps
Y N Bone / Joint Replacement	Y N Diabetes	Y N Hernia	Y N Pacemaker
Y N Artificial Valves	Y N Drug Abuse	Y N High Blood Pressure	Y N Pneumonia
Y N Asthma	Y N Emphysema	Y N HIV / AIDS	Y N Polio
Y N Bladder Infection	Y N Epilepsy	Y N Infectious Mono	Y N Psychiatric Problems
Y N Blood Transfusion	Y N Fever Blisters	Y N Kidney Problems	Y N Radiation Treatments
Y N Bronchitis	Y N Glaucoma	Y N Liver Problems	Y N Rheumatic Fever
Y N Cancer	Y N Hay Fever	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Chemotherapy	Y N Headaches	Y N Lupus	Y N Thyroid Problems
Y N Chicken Pox	Y N Heart Disease	Y N Measles	Y N Venereal Disease
Y N Rheumatoid Arthritis	Y N Stroke	Y N Ulcers	Y N Congenital Heart Defect

Please list any past Surgical History

PROCEDURE	***HOSPITAL***	***WHAT YEAR***
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Patient: _____Date of Birth: _____Today's Date_____

Patient's Initials _____

Family History

Has any member of your family (blood relative) had any of the following?

(Please use the abbreviations below to describe the family member(s) that has the illness, if you are unsure or do not know, please leave blank.)

M=Mother F=Father S-Sister B=Brother MGM= Maternal Grandmother
MGF=Maternal Grandfather PGM=Paternal Grandmother PGF= Paternal Grandfather

Cancer	**High Blood Pressure**
Chronic Lung Disease	**High Cholesterol**
Depression	**Kidney Disease**
Diabetes	**Mental Illness**
Drug or Alcohol Problems	**Migraine Headaches**
Epilepsy	**Stroke**
Glaucoma	**Thyroid Disease**
Heart Disease	**Ulcers**

	Present age or age of death	*If living, health (good, fair, poor)*	*If deceased, cause of death*
Father	_____	_____	
Mother	_____	_____	
Brothers/Sisters	_____	_____	
Spouse	_____	_____	
Children	_____	_____	

Please list all medicines you are presently taking including over the counter medicines such as aspirin, vitamins, antacids, sleep aides, allergy, cold medicines, etc...

Name of Medicine including strength ***How many times a day***

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Are you allergic to any medications? Yes No
(if yes, please list) _____

Please tell us if you: (Please circle your answer)

Do you smoke? Yes No Quit Year Quit_____ Packs per day? _____
Do you drink alcoholic beverage? Yes No If yes, what?_____ #perday/ month_____

ACKNOWLEDGEMENT

I affirm that I have answered all of the above correctly to the best of my knowledge. It will be held to the strictest of confidence and I understand that it is my responsibility to inform The DeWitt Clinic physician of any changes in my medical status.

_____ _____
Signature ***Date***

Reviewed by physician and/or medical assistant:

Date/Initials	*Date/Initials*	*Date/Initials*	*Date/Initials*	*Date/Initials*	*Date/Initials*	*Date/Initials*

Patient Authorization Information

***Patient: _____Date of Birth*: _____Today's Date:_____**

Authorization to Obtain Medical Records

I (We) authorize The DeWitt Clinic, PA and/or employees to access and/or obtain my medical records from any hospital, doctor's office and/or medical facility by any method including facsimile, computer, internet or written format in order to provide the appropriate medical care.

_____ _____

Signature of Patient and/or Parent or Legal Guardian ***Date***

Authorization/Agreement to pay for Services Rendered

I (We) agree to pay for all charges incurred during the course of treatment and/or services rendered. The DeWitt Clinic, PA will submit medical claims to my insurance company, and I understand that I am solely responsible for providing current health insurance information to The DeWitt Clinic. I further understand that I will be responsible for any charges not paid or covered by my health insurance plan should coverage be terminated or I fail to inform The DeWitt Clinic of any changes in my health care insurance coverage, including ID#, group #, coverage changes and any other information that causes the claim to be denied. I also understand that I am responsible for paying any co pays, coinsurance and/or deductibles. I also understand that I am responsible to pay any balances due at the time services are rendered or within 30 days from the date I receive a statement of balances due.

I realize that failure to keep my account current may result in my being unable to received additional services with the exception of emergency or when there is a payment plan in place. In case of default on payment of my account, I agree to pay collection fees and reasonable attorney fees incurred in attempting to collect on any outstanding balance.

_____ _____

Signature of Patient and/or Parent or Legal Guardian ***Date***

Acknowledgement of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I so choose.

_____ _____

Signature of Patient and/or Parent or Legal Guardian ***Date***

Release of Information

I authorize The DeWitt Clinic, PA, its agents, and employees to release, disclose, retain or obtain any or all of my medical or financial records to/from any entity including referring physicians, hospitals, pharmacies, labs, health care providers or answering service via telephone, facsimile, mail or electronic billing in order to provide with necessary medical care and insurance billing processes.

In addition, I also authorize The DeWitt Clinic, PA to release my medical information to any persons I have listed below:

Name	***Relationship***	***Telephone Number***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Signature of Patient and/or Parent or Legal Guardian ***Date***

In order that The DeWitt Clinic, PA and its staff to communicate necessary information to me, I authorize The DeWitt Clinic, PA to leave a message on my home telephone, cell telephone or at my employment if necessary.