GENERAL MEDICAL HISTORY FORM

If none apply, please check N, write N/A or NONE

MEDICAL HISTORY: Check if you have *EVER* had any of these *DIAGNOSED*

	Y	N		Y	N		Y	N
Anemia			Diabetes			Liver disease		
Ankle injury			Glaucoma			Low back injury/pain		
Anxiety			Gout			Mid back pain		
Arthritis			Heart Disease			Migraines		
Asthma			Hepatitis			Neck injury/pain		
Bleeding Disease			High blood pressure			Reflux		
Cancer			High cholesterol			Shoulder injury/pain		
Depression			Kidney disease			Seizures/Stroke		
Dermatitis/Skin Ds			Knee injury			Stroke		

OTHER:_____

_____

SURGICAL HISTORY

	Y	N	When		Y	N	When
Ankle surgery (R/L)				Knee surgery (R/L)			
Appendix removed				Low back surgery			
C-Section				Neck surgery			
Colonoscopy				Shoulder surgery (R/L)			
Gallbladder removed				Stress test			
Heart/stent/bypass				Tonsils removed			
Hernia repair				Tubal ligation			
Hysterectomy				Vasectomy			

OTHER:_____

_____

CURRENT MEDICATIONS: (Name-Dose)

_____

_____

_____

Do you have any ALLERGIES TO MEDICATIONS? NO □ YES □ Please list _____

FAMILY HISTORY

Mother	□Alive □Deceased	Cause of Death-
Father	□Alive □Deceased	Cause of Death-
Brother & Sisters	#____Alive #_____Deceased	Cause of Death-

Do you have any family history of:

	Y	N	Who & What Type		Y	N	Who
Cancer				Heart disease			
Diabetes				Other			

Tobacco- Do you currently use: □Cigarettes □Cigars □Snuff □Chewing tobacco □ None

How much in a day:_____ **How many months/years:**_____

Alcohol- Do you drink? □Never □Rarely □Monthly □Weekly □Daily

Shots: Tetanus shot in last 10 year? □Yes_____**(year) □No □Unknown**

Hepatitis B series? □Yes_____**(year completed) □No □Started not finished**

Family Doctor:_____ _____ **# Of Children**_____

Occupation:_____ _____ **Company:**_____

Number of years/months with current company: _____

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ACKNOWLDGEMENT OF RECIEPT, NOTICE OF PRIVACY PRACTICES

The federal HIPPA privacy rule requires our office to comply with certain legal requirements designed to protect your personal health information (PHI). HIPPA gives individuals the right to request a restriction on uses and disclosures of PHI. The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. We may need your written authorization to release PHI even if you are the one requesting the release.

Under certain conditions, for example worker's compensation, drug testing and employer directed examinations a release may not be required. If your employer has directed you to come to our office, your PHI may be released to the employer unless you indicate otherwise. Please let the office staff know if you have any questions about information that may be released at the time of your visit.

The goal of our office is to provide open communication with our patients. At your visit we provide you with the privacy information brochure, "We Care About Your Privacy" as well as have the information posted next to the receptionist desk. If you have any questions about the contents of the brochure please let us know.

Our usual methods for notifying patients are by way of mail or telephone. We will not leave confidential information on your voice mail unless it is deemed an emergency by the physician. We may leave you a reminder message about an upcoming appointment or information to call our office for results or to speak with the doctor. We make every attempt to keep your information confidential. We may also send post cards about upcoming appointments.

☐ ***I have read and agree with all the above listed ways of communication***

☐ ***I have read and do not agree with the above listed means of communication:***
Please explain below and notify the physician of your concerns:

_____
_____

If you would like to be contacted by other means please let us know by indicating below:

_____ _____
_____ _____

If you would like private information released to anyone other than yourself we must have their name and information in writing. You may list their information below. This release would authorize them to receive any and all information about the office visit, labs, etc.
I authorize release of private health care information to: Name / Address / Phone

_____ _____ _____
_____ _____ _____

Signature_____ ***Date_____***

You May Refuse to Sign This Acknowledgement

OFFICE USE ONLY
We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because ☐Individual refused to sign ☐Other: