

PATIENT INFORMATION

DATE: _____

Patient's Name: _____
(Last) (First) (Middle)

Address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Home Phone: () _____ Work Phone: () _____

Sex: _____ Marital Status: _____ Date of Birth: _____ SS#: _____

Patient's Employer: _____

Address: _____
(City) (State) (ZIP)

Spouse's Name: _____

Spouse's Employer: _____

& Address: _____
(City) (State) (ZIP)

Referred by: _____

Notify in Case of Emergency:

Name: _____ Phone: _____ Relationship: _____

1st Insurance Company: _____

Policy Holder's Name: _____ Co-Pay: _____

ID#: _____ Group #: _____ Date of Birth: _____

2nd Insurance Company: _____

Policy Holder Name: _____

ID#: _____ Group #: _____ Date of Birth: _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

This office does not accept responsibility for collecting your insurance proceeds or for the negotiating settlement of a disputed claim. If for whatever reason your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charge or collection fees that may be included.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits payable for services provided by Robert W. Fayle, M.D., including Medicare, Medicaid, private insurance and any other health plans to Robert W. Fayle, M.D. I further authorize a release of any medical information necessary to process the claim and payment of benefits. A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until revoked by me in writing.

Date: _____ Signature: _____

NAME _____

DATE _____

(Please Print)

REFERRING OR PRIMARY PHYSICIAN _____

MEDICAL HISTORY QUESTIONNAIRE

CHIEF COMPLAINT or MAIN PROBLEM:

KNOWN ALLERGIES:

CURRENT MEDICATIONS:

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

SURGERIES / MAJOR ILLNESSES / INJURIES

REVIEW OF SYSTEMS: Please mark all your symptoms, conditions or problems

GENERAL

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> FEVERS | <input type="checkbox"/> CHILLS | <input type="checkbox"/> SWEATS |
| <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> "FEELING SICK" |
| <input type="checkbox"/> FATIGUE (Always Tired) | | <input type="checkbox"/> NONE |

VISION

- | | | |
|--|--|--|
| <input type="checkbox"/> VISION LOSS (One Eye) | <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> EYE IRRITATION |
| <input type="checkbox"/> VISION LOSS (Both Eyes) | <input type="checkbox"/> BLURRING | <input type="checkbox"/> EYE PAIN |
| <input type="checkbox"/> "HALOS" AROUND LIGHTS | <input type="checkbox"/> DISCHARGE | <input type="checkbox"/> LIGHT SENSITIVITY |
| | <input type="checkbox"/> NONE | |

EARS, NOSE, THROAT

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> EAR DISCHARGE | <input type="checkbox"/> EARACHE |
| <input type="checkbox"/> DECREASED HEARING | <input type="checkbox"/> NASAL CONGESTION | <input type="checkbox"/> NOSEBLEEDS |
| <input type="checkbox"/> DIFFICULTY SWALLOWING | <input type="checkbox"/> HOARSENESS | <input type="checkbox"/> SORE THROAT |
| | <input type="checkbox"/> NONE | |

HEART

- | | | |
|--|--|--|
| <input type="checkbox"/> DIFFICULTY BREATHING AT NIGHT | <input type="checkbox"/> RACING/SKIPPING HEART BEATS | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> DIFFICULTY BREATHING LYING DOWN | <input type="checkbox"/> BLUISH COLOR OF LIPS OR NAILS | <input type="checkbox"/> SHORTNESS OF BREATH ON EXERTION |
| <input type="checkbox"/> CHEST PAIN OR DISCOMFORT | <input type="checkbox"/> LIGHTHEADEDNESS | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> SWELLING OF HANDS OR FEET | <input type="checkbox"/> LEG CRAMPS WITH EXERTION | <input type="checkbox"/> NEAR FAINTING |
| | <input type="checkbox"/> NONE | |

---NEXT PAGE---

BREATHING

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> EXCESSIVE SPUTUM | <input type="checkbox"/> COUGH |
| <input type="checkbox"/> COUGHING UP BLOOD | <input type="checkbox"/> CHEST DISCOMFORT | <input type="checkbox"/> WHEEZING |
| <input type="checkbox"/> | <input type="checkbox"/> NONE | <input type="checkbox"/> |

STOMACH AND BOWELS

- | | | |
|---|---|---|
| <input type="checkbox"/> EXCESSIVE APPETITE | <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> INDIGESTION |
| <input type="checkbox"/> CHANGE IN BOWEL HABITS | <input type="checkbox"/> NAUSEA | <input type="checkbox"/> VOMITING |
| <input type="checkbox"/> YELLOWISH SKIN COLOR | <input type="checkbox"/> GAS | <input type="checkbox"/> ABDOMINAL PAIN |
| <input type="checkbox"/> ABDOMINAL BLOATING | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> DARK TARRY STOOLS | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> VOMITING BLOOD |
| <input type="checkbox"/> BLOODY STOOLS | <input type="checkbox"/> NONE | |

MUSCULOSKELETAL

- | | | |
|---|---|---|
| <input type="checkbox"/> JOINT SWELLING | <input type="checkbox"/> JOINT PAIN | <input type="checkbox"/> MUSCLE CRAMPS |
| <input type="checkbox"/> PRESENCE OF JOINT FLUIDS | <input type="checkbox"/> STIFFNESS | <input type="checkbox"/> BACK PAIN |
| <input type="checkbox"/> GOUT | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> MUSCLE WEAKNES |
| <input type="checkbox"/> MUSCLE ACHES | <input type="checkbox"/> LOSS OF STRENGTH | <input type="checkbox"/> NONE |

GENITO-URINARY

- | | | |
|---|--|--|
| <input type="checkbox"/> URINARY FREQUENCY | <input type="checkbox"/> BLOOD IN URINE | <input type="checkbox"/> FOUL URINARY DISCHARGE |
| <input type="checkbox"/> INABILITY TO EMPTY BLADDER | <input type="checkbox"/> URINARY URGENCY | <input type="checkbox"/> KIDNEY PAIN |
| <input type="checkbox"/> ABNORMAL VAGINAL BLEEDING | <input type="checkbox"/> EXCESSIVELY HEAVY PERIODS | <input type="checkbox"/> TROUBLE STARTING URINARY STREAM |
| <input type="checkbox"/> LACK OF SEXUAL DRIVE | <input type="checkbox"/> GENITAL SORES | <input type="checkbox"/> MISSED PERIODS |
| <input type="checkbox"/> UNUSUAL URINARY COLOR | <input type="checkbox"/> PAINFUL URINATION | <input type="checkbox"/> PELVIC PAIN |
| <input type="checkbox"/> NIGHT TIME URINATION | <input type="checkbox"/> NONE | |

SKIN

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> POOR WOUND HEALING | <input type="checkbox"/> EXCESSIVE PERSPIRATION | <input type="checkbox"/> NIGHT SWEATS |
| <input type="checkbox"/> UNUSUAL HAIR DISTRIBUTION | <input type="checkbox"/> CHANGES IN NAIL BEDS | <input type="checkbox"/> DRYNESS |
| <input type="checkbox"/> CHANGES IN SKIN COLOR | <input type="checkbox"/> SKIN CANCER | <input type="checkbox"/> FLUSHING |
| <input type="checkbox"/> ITCHING | <input type="checkbox"/> RASH | <input type="checkbox"/> NONE |

NEUROLOGIC

- | | | |
|---|---|---|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> POOR BALANCE | <input type="checkbox"/> INABILITY TO SPEAK |
| <input type="checkbox"/> DIFFICULTY CONCENTRATING | <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> FALLING DOWN |
| <input type="checkbox"/> DISTURBANCES IN COORDINATION | <input type="checkbox"/> SENSATION OF ROOM SPINNING | <input type="checkbox"/> TINGLING |
| <input type="checkbox"/> WEAKNESS | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> TREMORS |
| <input type="checkbox"/> BRIEF PARALYSIS | <input type="checkbox"/> FAINTING | <input type="checkbox"/> MEMORY LOSS |
| | <input type="checkbox"/> NONE | |

SLEEP

- | | | |
|--|---|---|
| <input type="checkbox"/> EXCESSIVE DAYTIME SLEEPINESS | <input type="checkbox"/> SLEEP ATTACKS | <input type="checkbox"/> SNORING |
| <input type="checkbox"/> DISTURBED SLEEP DUE TO PROBLEMS BREATHING | <input type="checkbox"/> DROWSINESS WHILE DRIVING | <input type="checkbox"/> SLEEP ONSET HALLUCINATIONS |
| <input type="checkbox"/> "RESTLESS" FEELING IN LEGS | <input type="checkbox"/> SLEEP WALKING/TALKING | <input type="checkbox"/> ACTING OUT DREAMS |
| <input type="checkbox"/> PARALYSIS AT SLEEP ONSET | <input type="checkbox"/> NONE | |

PSYCHIATRIC

- | | | |
|---|--|--|
| <input type="checkbox"/> THOUGHTS OF SUICIDE | <input type="checkbox"/> SENSE OF GREAT DANGER | <input type="checkbox"/> ANXIETY |
| <input type="checkbox"/> THOUGHTS OF VIOLENCE | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> MENTAL PROBLEMS |
| <input type="checkbox"/> FRIGHTENING VISIONS/SOUNDS | <input type="checkbox"/> NONE | |

ENDOCRINE

- | | | |
|---|---|--|
| <input type="checkbox"/> HEAT INTOLERANCE | <input type="checkbox"/> COLD INTOLERANCE | <input type="checkbox"/> EXCESSIVE HUNGER |
| <input type="checkbox"/> WEIGHT CHANGE | <input type="checkbox"/> EXCESSIVE THIRST | <input type="checkbox"/> EXCESSIVE URINATION |
| | <input type="checkbox"/> NONE | |

HEME/LYMPHATIC

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> SKIN DISCOLORATION | <input type="checkbox"/> BLEEDING | <input type="checkbox"/> FEVERS |
| <input type="checkbox"/> ENLARGED LYMPH NODES | <input type="checkbox"/> ABNORMAL BRUISING | <input type="checkbox"/> NONE |

ALLERGIC/IMMUNOLOGICAL

- | | | |
|---|--|--|
| <input type="checkbox"/> SEASONAL ALLERGIES | <input type="checkbox"/> PERSISTENT INFECTIONS | <input type="checkbox"/> HIVES OR RASH |
| <input type="checkbox"/> HIV EXPOSURE | <input type="checkbox"/> NONE | |

FAMILY HISTORY (*Illnesses that run in family*)

<i>RELATIVE</i>	<i>HEALTH</i>	<i>ALIVE</i>	<i>DECEASED</i>	<i>AGE</i>
MOTHER				
FATHER				
BROTHER(S)/SISTER(S)				
CHILD(REN)				

SOCIAL HISTORY:

TYPE OF WORK: _____

SMOKE?		YES	NO	How much? _____
DRINK?	COFFEE	YES	NO	How many cups? _____
	OTHER CAFFEINE	YES	NO	How much? _____
	ALCOHOL	YES	NO	How much? _____

COMMENTS:

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

