Name: _____ SS# _____

General Medical Information

Describe the current medical problem/reason for today's visit: _____

_____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

_____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? __Yes __No

Do you smoke? __Yes __No

__Cigarettes __Pipe __Cigars No. of yrs__ How many? __

Interested in stopping? __Yes __No

Do you regularly drink alcohol? __Yes __No How many ounces/beers per day? _____

Do you regularly drink coffee? __Yes __No How many cups per day? _____

Are you under a lot of pressure at work? __Yes __No please describe: _____

Personal Medical History

Have you ever had any of the following (check all that apply):

__Chest pain/ pressure/ tightening	__Asthma	__Kidney disease
__Hypertension	__Dizzy spells	__SOB
__Heart attack	__Cancer	__TB/Lung disorder
__Stroke	__Diabetes	__Ulcers
__Headaches	__Arthritis	__Skin disorders
__Glaucoma	__Difficulty hearing	__Hepatitis
__Allergies or eczema	__Anemia	__Cataracts
__Depression	__Memory Loss	__Digestive problems
__Blood in stool	__Hemorrhoids	__Frequent urinary infect

__Other_____

Hepatitis C risk Factor

__Blood transfusion prior to 1992	__Tattoos
__IV drug use (1+ times)	__Shared razor/toothbrush
__Contact with bloody/bodily fluids	__Body piercing

Immunizations

(Year last received, if known)

Smallpox_____	Influenza_____
Tetanus_____	Pneumonia_____
Typhoid_____	Rubella_____
Polio_____	Hepatitis_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Child
High Blood Pressure	___	___	___	___	___	___
Epilepsy	___	___	___	___	___	___
Cancer	___	___	___	___	___	___
Eczema/Psoriasis	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___
Heart Attack/ Stroke	___	___	___	___	___	___
Asthma	___	___	___	___	___	___
Hay Fever	___	___	___	___	___	___

Emergency Contact

Name:_____ Tel # (___) ___-____ Relationship_____
Name:_____ Tel # (___) ___-____ Relationship_____

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
Date: _____ Signature: _____

I hereby authorize Dr. **Michele Martin-Jones** to apply for benefits on my behalf for covered services rendered by her or her order. I request that payment from my insurance company be made directly to Dr. **Michele Martin-Jones** (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date_____ Signature_____
(patient, parent, or guardian)