New patient health history
General information

Name _____ ☐ female ☐ male Birthdate_____Age____

Address _____City _____ State _____ Zip _____

Telephone (home) _____ (work)_____(cell)_____

Email address _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Living situation: ☐ alone ☐ friends ☐ partner ☐ spouse ☐ parents Number of children _____

Occupation _____ Employer _____

Employer address _____

Employment status: ☐ full-time ☐ part-time ☐ school ☐ retired ☐ unemployed other _____

Name of Partner/Spouse/Parent: _____

Circle one

Emergency contact _____ Relationship _____

Address _____ Telephone _____

How did you hear about us? Phone book____ Insurance ____ Other _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

I herby authorize the release of any medical information necessary to in the processing of my medical claim. I also authorize payment directly to HealthMax for the medical benefits.

I authorize my practitioner to examine and treat me, to consult with another healthcare practitioner in regards to continuing my care.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed _____ Date _____

Patient, parent or guardian of minor

In your opinion, what are your most important physical, emotional, or mental health problems? Indicate which is/are of the most immediate concern to you.

1. _____
2. _____
3. _____
4. _____
5. _____

How do you rate your overall health? Excellent Good Fair Poor

What are your expectations for today's visit? _____

_____

What are your expectations for our work together in general? _____

_____

_____

Hospitalizations

What hospitalizations or surgeries have you had? When did they occur? _____

_____

_____

Special studies

What diagnostic imaging studies have you had? (i.e. X-rays, CT scan, mammogram, MRI, bone density scan, EKG. EEG) _____

_____

_____

Blood work

Date of last blood test? _____ What tests did you have(if known) _____

_____

Childhood Illnesses

Rubella (german, 3 day measles) _____	Measles (two week) _____	Roseola _____
Whooping cough _____	Chicken pox _____	Mumps _____
Rheumatic Fever _____	Asthma _____	Polio _____
Scarlet Fever _____	Diphtheria _____	

Immunizations

Polio	Y	N	Pertussis	Y	N
Tetanus	Y	N	Diphtheria	Y	N
Measles/Mumps/Rubella (MMR)	Y	N	Other _____		

Your health history

Now	Past	Never		Now	Past	Never	
____	____	____	Allergies	____	____	____	Heart Murmur*
____	____	____	Anemia	____	____	____	High Blood Pressure
____	____	____	Arthritis	____	____	____	Injury (serious)
____	____	____	Asthma	____	____	____	Kidney Disease
____	____	____	Alcoholism	____	____	____	Liver Disease
____	____	____	Bleeding problem	____	____	____	Overweight
____	____	____	Cancer	____	____	____	Pneumonia
____	____	____	Candida(yeast)	____	____	____	Polio
____	____	____	Colitis	____	____	____	Rheumatism
____	____	____	Drugs/Alcohol use*	____	____	____	Thyroid Problem
____	____	____	Eczema	____	____	____	Tuberculosis
____	____	____	Emphysema	____	____	____	Sexually Trans. Disease
____	____	____	Headache	____	____	____	Others*

*Please specify _____

Family history

Please list the ages of your family members and any medical problems they have had. If deceased, please list age of death and cause.

Mother's side

Grandfather _____

Grandmother _____

Mother _____

Father's side

Grandfather _____

Grandmother _____

Father _____

Sisters _____

Brothers _____

Are there any stories in your life history that would help you and I to work together better?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____