Patient Profile Sheet

PLEASE PRINT CLEARLY

Name:_____ Date:_____

Address:_____
Street City/State/Zip Code

Phone: _____ _____ _____
Home Work Cell

Email:_____

Age:_____ DOB:_____ Occupation:_____

Employer:_____

SSN:_____ Drivers License: State _____ #_____

EMERGENCY Contact _____ Phone _____

Pharmacy Information: _____

HIPAA PRIVACY NOTICE
This form is intended for the use and/or disclosure of Protected Health Information (PH) when providing or seeking treatment, payment, and healthcare operations

1. This privacy Notice contains a thorough and complete description of the uses and/or disclosures of my protected health information ("PH") which are necessary to provide me with treatment, and which are also necessary for the Practice to obtain payment for that treatment and to perform other healthcare operations. I have been informed that, upon my request, the privacy notice will be made available to me. Prior to signing this Agreement, the Practice advised me of my right to obtain a copy of the Privacy Notice and has encouraged me to read it in its entirety, in accordance with applicable law.
2. To protect your privacy and to remain in compliance with applicable law, the Practice reserves the right to change the practices depicted in its Privacy Notice.
3. I am aware that the Practice's "Notice of Privacy Practices" is displayed in the waiting area and that I am free to request a copy of the same at any time.
4. The Notice of Privacy Practices contains my rights, as well as the duties and obligations of this office as it relates to my protected health information.

I have read and understand this notice in its entirety and agree that any questions I may have had have been answered to my full and complete satisfaction and understanding.

_____ _____
Name of Individual (Printed) Signature of Individual

MEDICAL QUESTIONNAIRE

Please circle your answer

MEDICAL HISTORY

ARTHRITIS	YES	NO	HEADACHES	YES	NO
DIABETES	YES	NO	HIGH CHOLESTEROL	YES	NO
HIGH BLOOD PRESSURE	YES	NO	BLOCKED ARTERY	YES	NO
HEART ATTACK	YES	NO	STROKE	YES	NO
HEART DISEASE	YES	NO	PARKINSON'S DISEASE	YES	NO
MULTIPLE SCLEROSIS	YES	NO	LIVER DISEASE	YES	NO
EPILEPSY	YES	NO	KIDNEY DISEASE	YES	NO
HEPATITIS	YES	NO	PROSTATE PROBLEMS	YES	NO
BOWEL PROBLEMS	YES	NO	ACUTE PAIN OR SWELLING	YES	NO
CANCER	YES	NO	HIV INFECTION / AIDS	YES	NO
BLOOD TRANSFUSION	YES	NO	MAJOR DEPRESSION	YES	NO
TUBERCULOSIS	YES	NO	BLEEDING DISORDER	YES	NO
URO-GENITAL PROBLEMS	YES	NO	SKIN PROBLEMS	YES	NO
SICKLE CELL DISEASE (ANEMIA)	YES	NO	SEXUALLY TRANSMITTED	YES	NO
SICKLE CELL DISEASE TRAIT ONLY	YES	NO	HERPES	YES	NO
PEYRONIE'S DISEASE	YES	NO	MALARIA	YES	NO
FABRY'S DISEASE	YES	NO	LEUKEMIA	YES	NO

OTHER _____

Please list any current medications: _____

_____

SURGERIES

_____

_____

_____

FAMILY HISTORY

DIABETES	YES	NO	HEART DISEASE	YES	NO
CANCER	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS	YES	NO	EXCESSIVE WEIGHT	YES	NO
MIGRAINES	YES	NO	HAIR LOSS / BALDNESS	YES	NO

OTHER SIGNIFICANT AILMENTS _____

ALLERGIES

HAVE YOU HAD AN ALLERGIC REACTION TO ANY MEDICATION YES NO

IF YES PLEASE PROVIDE DETAILS_____

_____

Female Patients Please list the Number of Pregnancies, Live Births, and Miscarriages

_____

Reason for seeking care:

_____
_____
_____
_____

Have you had care/treatment for this issue before? If yes, what type of care/treatment was provided:

_____
_____
_____
_____

Do you smoke: _____ Do you drink alcohol? If yes how often: _____

Do you use illicit drugs? If yes what type of drugs: _____