Peak Medical & Wellness Centers

New Patient Registration/Health History

Name _____ **Date**_____

Sex_____ **Home phone**_____ **Cell Phone**_____

Address_____

City State Zip

Date of Birth_____(MM/DD/YYYY) **Email Address**_____

Occupation_____

Marital Status: •Single •Married •Divorced •Separated •Widowed

Height_____ **Weight**_____

Referred by_____

Medical Doctor's Name, City, and phone number_____

_____

Orthopedic Doctor's Name, City & phone number_____

_____

Have you ever experienced any of the following?

•Car Accidents •Falls •Sports Injuries •Workman's Compensation

•Fractures

Past Medical History

•Anemia •Angina •Anxiety •Arthritis

•Ascites •Asthma •Bladder Problems •Bleeding Abnormalities

•Blood Clots •Cancer •Cirrhosis •COPD

•Concussion •Depression •Diabetes (Type1/Type 2)

•Epilepsy/Seizures •Eye/vision problems •Fibromyalgia •Glaucoma

•Headaches •Hearing Problems •Heart Attack •Heart Disease

•Heart Failure •Hepatitis •High Blood Pressure •High Cholesterol

•HIV •Incontinence •Insomnia •Jaw Pain/TMJ

•Kidney disease •Kidney stones •Liver Problems •Lupus

•Lyme's Disease •Memory Loss •Menstrual Problems •Migraines

•Multiple Sclerosis •Osteopenia •Osteoporosis •Parkinson's Disease

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•Pleural Effusion	•Polio	•Prostate Problems	•Psoriasis
•Pulmonary edema	•Rheumatoid Arthritis	•Scoliosis	•Spinal Cord Injury
•Stomach/GI Problems	•Stroke/TIA	•TB	•Thyroid Disorder
•Tremors	•Ulcers	•Vascular Conditions	•Vertigo

Other:_____

Are you currently pregnant? •N/A •No •Yes

If yes, how many weeks pregnant?_____

Are you currently breast feeding? •N/A •No •Yes

Past Surgical History (Please list ALL surgeries and estimated date)_____

_____

_____

_____

Medications/Supplements (Please list ALL prescribed medications, vitamins, supplements, or over the counter medications you are currently taking. Include Birth control, Insulin, Inhalers, or any topical medications)_____

_____

_____

_____

_____

_____

Significant family history (parents and siblings)_____

_____

Please list any known medication allergies_____

_____

Do you use Tobacco products? No Yes (If yes, please answer the following questions)

What kind of Tobacco products do you use?

•Cigarettes •Cigars •Chewing Tobacco •Other:_____

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On average, how many cigarettes/ cigars per day do you smoke? (Please pick one)

•I smoke but not every day •1-10 •11-20 •21-30 •More than 30

If you use a form of tobacco other than cigarettes or cigars, how many times per day do you use it?

•I don't use every day •1-10 •11-20 •21-30 •More than 30

How many years have you been using tobacco products? _____

Are you interested in quitting? •No •Yes

Do you consume alcohol? •No •Yes (If yes, please answer the following questions)

How often do you have a drink containing alcohol? (Please pick one)

•Monthly/less •2-4 times a month •2-3 times a week •4/more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

•1-2 •3-4 •5-6 •7-9 •10/more

Review of systems

Allergic-Immunologic: Negative___

__Hives/Eczema __Seasonal Allergies

Cardiovascular: Negative ___

__Chest Pain __Palpitations __Swollen Ankles

__Irregular Heartbeat __Fainting Spells

Constitutional: __Negative

__Fatigue __Fever __Unintentional Weight Loss

__Loss of Appetite

Ear/Nose/Throat: __Negative

__Difficulty Hearing __Ringing in Ear(s) __Vertigo

__Ear Pain __Chronic Sinus Problems __Nasal Congestion

__Nose Bleeds __Mouth Sores __Hoarseness

__Frequent sore Throat __Difficulty Swallowing __Dental Problems

Endocrine: __Negative

__Hair Loss __Heat/cold Intolerance __Recent Weight Gain

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Eyes: __Negative

__Glasses/Contacts __Eye Pain __Sensitivity to Light

__Blurred Vision

Gastro-Intestinal: __Negative

__Heartburn/Reflux __Nausea/Vomiting __Constipation

__Diarrhea __Black or Bloody Stools

Date of Last Colonoscopy:_____

Genitourinary: __Negative

__Burning upon urination __Blood in Urine __Urinary Incontinence

__Urinary Frequency __Fowl smelling Urine

Hematology/Lymph: __Negative

__Anemia __Easy Bruising __Gums Bleed Easily

__Enlarged Lymph nodes

Musculoskeletal: __Negative

__Joint Pain __Joint Swelling __Joint Stiffness

__Muscle Spasms __Muscle Weakness __Neck Pain

__Stiff Neck __Low Back Pain

Neurological: __Negative

__Loss of Strength __Numbness __Tingling

__Heavy Head __Tremors __Loss of Coordination

__Difficulty in walking __Weakness

Psychiatric: __Negative

__Anxious __Depressed __Difficult Sleeping

Respiratory: __Negative

__Shortness of Breath __Wheezing __Chronic cough

Integumentary (Skin): __Negative

__Rash/Sores __Lesions __Itching/Burning

__Change in moles

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Women's Health: __Negative

__Abnormal vaginal bleeding __Menstrual cramps

Date of Last Mammogram: _____ Normal____ Abnormal____

Date of Last PAP: _____ Normal____ Abnormal ____

Periods Regular? ___Normal ___Abnormal

Number of Pregnancies ___

Men's Health: __ Negative

__Frequent urination at night __Difficulty in starting urine

__Erectile Dysfunction

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ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

I have received / reviewed a copy of Peak Medical & Wellness Centers Notice of Privacy Practice:

Patient's Name DOB Signature of Patient Date

DESIGNATION OF RELATIVES, FRIENDS, AND OTHER CAREGIVERS FOR HEALTHCARE DISCLOSURE

I agree that Peak Medical & Wellness Centers may disclose certain healthcare information to persons involved with my healthcare decisions of payment, I designate the following person (s) listed below as being involved with my healthcare for the purpose of Peak Medical & Wellness Centers making limited information disclosure for the above purpose. I UNDERSTAND I AM NOT REQUIRED TO LIST ANYONE. I also understand I may change the designees in writing at any time.

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

MEDICARE PATIENT CERTIFICATION- PATIENTS – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:

I certify that the information given by me in applying for payment under Title XVII and / or Title XI of Social Security Act is correct. I authorize any holder of medical or other information needed for this or related to Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

RELEASE OF INFORMATION:

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

INFORMED CONSENT

I hereby request and consent to the performance of: physical examination, any other diagnostic tests such as x-rays to diagnose my condition(s), and treatment(s). This consent will cover the entire course of my treatment(s) for present conditions or any further conditions for which I seek treatment(s).

Patient's Signature: _____ Date: _____

I case of emergency, contact _____ Phone #_____

Complete if Patient is under 18 Years of Age:

As parent/legal guardian of above child, I understand the terms above and grant permission for treatment.

Patient/Guardian Signature: _____ Date: _____

PREGNANCY

By my signature on this form I do hereby state that to the best of my knowledge:

- ☐ I am NOT PREGNANT, nor is PREGNANCY SUSPECTED OR CONFIRMED at this particular time.
- ☐ I AM currently _____ weeks pregnant.

Patient's Signature: _____ Date: _____