Dear Patient: *This information is considered confidential. In order for us to understand your condition properly, please be as thorough, neat, and accurate as possible while completing this form. Thank you.*

QUINCE ORCHARD MEDICAL CENTER
Pain relief lives here

PATIENT INFORMATION

Name_____

Address _____

City_____State_____Zip _____

Occupation _____

Employer_____

Address _____

City_____State_____Zip _____

Sex: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Other

Birthdate: ___/___/_____ Height:_____ Weight: _____

Home #_____ Work #_____

Cell #_____ Email _____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Referred By _____

Physician Patient Internet Coupon

INSURANCE INFORMATION

Policy # _____

Group # _____

Name of Insured _____

Related to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Guardian

Type of Insurance: ❑ Group ❑ Private ❑ Work/Comp ❑ Automobile

Insurance Company _____

Insurance Co. Phone_____

Policy Holder Social Security Number __ __ __-__ __-__ __ __ __

REASON FOR VISIT

Current Complaint _____

When Did Symptoms Start_____

What Makes You Feel Better_____

What Makes You Feel Worse_____

Symptoms Are: ❑ Constant ❑ Come & Go

Symptoms Are: ❑ Improving ❑ Getting Worse ❑ About the Same

Condition Due To: ❑ Auto Accident ❑ Work Injury ❑ Unknown ❑ Other

I Have: ❑ Loss of Bowel or Bladder Control ❑ Pain on Coughing/Sneezing

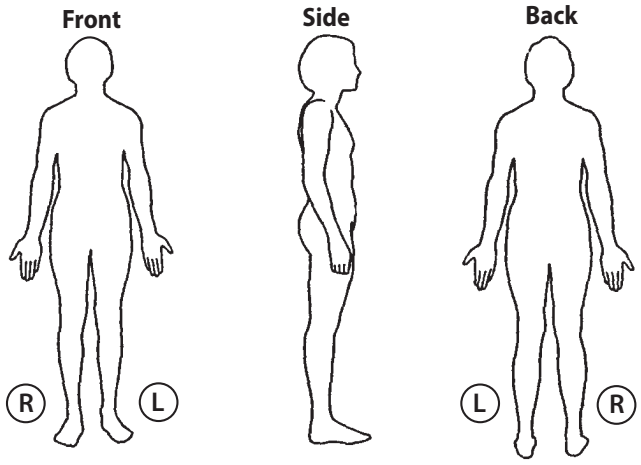
Emergency Contact Name_____

Phone Number _____ Relationship _____

Where may we leave a detailed message including your medical information, if necessary? ❑ Home ❑ Work ❑ Cell

Primary Care Physician _____

PLEASE USE ILLUSTRATION BELOW TO DIAGRAM YOUR SYMPTOMS



X=pain B=burning N=numbness O=other type of symptom

CURRENT MEDICAL HISTORY

Date of Last Physical Examination ___/___/_____ Any Allergies to Medications? _____

Current Assistive Devices (cane, crutches, etc.)_____

Current Medications *(including over the counter meds)*_____

_____

Radiological Tests Related to **Current** Medical Complaint: ❑ X-ray ❑ MRI ❑ CT Scan ❑ EMG ❑ NCV ❑Other_____

Prior Treatments for **Current** Condition (surgery, injections, acupuncture, etc.) _____

PAST MEDICAL HISTORY

Please check all appropriate boxes and fill in LOCATIONS if indicated

❑ Osteoporosis
❑ Osteoarthritis: _____
❑ Bone fractures: _____
❑ Rheumatoid Arthritis
❑ Whiplash
❑ Asthma
❑ Emphysema
❑ Anemia

❑ Diabetes: ❑ Type 1 ❑ Type 2
❑ Lyme Disease
❑ Gout
❑ Hearing Impairment
❑ Fatigue
❑ Hernia
❑ Multiple Sclerosis

❑ High Cholesterol
❑ Cardiovascular Disease
❑ Heart Attack
❑ Epilepsy
❑ Stroke
❑ Cancer _____
❑ Other _____
_____

Please also circle any items above that are common to other family members

Past Surgeries/Dates: _____

_____

Past/Current Treatment for Cancer: _____

_____

Are you currently pregnant or planning pregnancy? ❑ Yes ❑ No Date of last period _____

HABITS: ❑ Alcohol ❑ Coffee ❑ Tobacco ❑ Drugs ❑ Other _____

Patient Pharmacy Name: _____ Pharmacy ID: _____

Patient Pharmacy Address: _____ Pharmacy Phone: _____

REVIEW OF SYMPTOMS

Please check any of the following symptoms you have:

General

❑ Dizziness
❑ Balance Problems
❑ Migraine Headaches
❑ Swollen Joints
❑ Depression/Mood Swings
❑ Hearing Impairment
❑ Chest Pain
❑ Difficulty Breathing
❑ Abdominal Pain
❑ Stress/Fatigue
❑ Loss of Balance
❑ Weakness of Arm or leg
❑ Blood in Urine
❑ Frequent Urination
❑ Menopausal

Cardiovascular

❑ High Blood Pressure
❑ Low Blood Pressure
❑ Poor Circulation
❑ Pain Over Heart
❑ Hardening of Arteries
❑ Irregular Heartbeat

Skin

❑ Easy Bruising
❑ Skin Dryness
❑ Skin Eruptions/Rash
❑ Skin Disease
❑ Varicose Veins

Gastrointestinal

❑ Colon Trouble
❑ Constipation
❑ Diarrhea
❑ Blood in Stool
❑ Difficult Digestion
❑ Nausea/Vomiting
❑ Distended Abdomen
❑ Hemorrhoids
❑ Liver Disease
❑ Other _____
_____
_____
_____

By signing below, I acknowledge the above information is correct, and if indicated, I consent to allow Quince Orchard Medical Center contact me as specified. Quince Orchard Medical Center will only send appointment reminders and emergency messages by text and email and will not give out or sell this information to any marketing group.

_____ DATE ___/___/_____

Signature of Patient, Parent or Legal Guardian