*Thank you for choosing our office. In order to serve you properly, we will need the following information.* Please Print. All information is strictly confidential.

PATIENT INFORMATION

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_\_ SEX: M / F

(LAST) (FIRST) (MI)

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(STREET) (CITY) (STATE) (ZIP CODE)

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YOUR S.S.# \_\_\_\_\_\_- \_\_\_\_-\_\_\_\_\_\_\_

PHONE: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Work/Mobile Home/Work/Mobile

MARITAL STATUS: Single Married Divorced Widowed Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW DID YOU HEAR ABOUT OUR OFFICE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY INFORMATION *COMPLETE ONLY IF PATIENT IS NOT RESPONSIBLE PARTY*

RESPONSIBLE PARTY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(LAST) (FIRST) (MI)

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(STREET) (APT#) (CITY) (STATE) (ZIP CODE)

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXT:\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION *PLEASE COMPLETE AND GIVE OFFICE COPIES OF YOUR CARD(S)*

PRIMARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_

(INSURANCE COMPANY / PLAN NAME)

GROUP NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(INSURANCE COMPANY / PLAN NAME)

GROUP NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT

PERSON TO NOTIFY IN CASE OF EMERGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE# \_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY

NAME OF PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAYMENT FOR SERVICES I understand that it is my responsibility to verify with my insurance carrier if my physician is a participating provider, I realize that I am financially responsible for all medical and laboratory services rendered to me and / or my dependants regardless of the decision involving reimbursement by my insurance carrier.

INSURANCE, SERVICES & TREATMENT AUTHORIZATION

I hereby authorize payment of any medical benefits directly to Dr. Ben Littlejohn M.D. otherwise payable to me for rendered services as described on the attached claim. I authorize Dr. Ben Littlejohn M.D. to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company.

I also hereby authorize Dr. Ben Littlejohn M.D. and its medical staff to provide medical treatment and/or medical services to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME (PLEASE PRINT)

FOR OUR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Ben Littlejohn M.D., or any services furnished to me by one of their physicians. I authorize any holder of medical information about me to release that information to the Dr. Ben Littlejohn Inc. Administration and its agents including any information needed to determine these benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on the claim form, my signature authorizes release of the information to the insurer or agency shown. I understand that by accepting Medicare assignments, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE DATE PATIENT NAME (PLEASE PRINT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICARE #

“DECLARATION”

I declare under penalty of perjury that all information contained in this document is true and factual to the best of my knowledge.

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE DATE PATIENT NAME (PLEASE PRINT)

­­­­­­­­­­­­­­­­­­­Your Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you taking now (Name and Dosages):

­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY ALLERGIES TO MEDICATION? 🞏 YES 🞏 NO

If yes, please name the medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST OR CURRENT MEDICAL CONDITIONS

Check those that you have had an insert APPROXIMATE DATE

GENERAL

🞏 Recent weight change \_\_\_\_\_\_\_\_ 🞏 Fatigue \_\_\_\_\_\_\_\_

🞏 Poor Appetite \_\_\_\_\_\_\_\_ 🞏 Night Sweats \_\_\_\_\_\_\_\_

LUNGS

🞏 Pneumonia \_\_\_\_\_\_\_\_ 🞏 Shortness of breath \_\_\_\_\_\_\_\_

🞏 Asthma \_\_\_\_\_\_\_\_ 🞏 Chronic Cough \_\_\_\_\_\_\_\_

🞏 Tuberculosis \_\_\_\_\_\_\_\_ 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEART AND VASCULAR SYSTEM

🞏 Hypertension \_\_\_\_\_\_\_\_ 🞏 High Cholesterol \_\_\_\_\_\_\_\_

🞏 Heart Failure \_\_\_\_\_\_\_\_ 🞏 Heart Attack \_\_\_\_\_\_\_\_

🞏 Palpitations \_\_\_\_\_\_\_\_ 🞏 Varicose Veins \_\_\_\_\_\_\_\_

🞏 Swelling of ankles or legs \_\_\_\_\_\_\_\_ 🞏 Chest Pain \_\_\_\_\_\_\_\_

🞏 Leg cramps - During rest or activity \_\_\_\_\_\_\_\_

HEMATOLOGY

🞏 Easy Bruising \_\_\_\_\_\_\_\_ 🞏 Anemia \_\_\_\_\_\_\_\_

🞏 History of transfusion \_\_\_\_\_\_\_\_ 🞏 Bleeding \_\_\_\_\_\_\_

DIGESTIVE SYSTEM

🞏 Abdominal pain/ Heart burn \_\_\_\_\_\_\_\_ 🞏 Gallstones \_\_\_\_\_\_\_\_

🞏 Hepatitis \_\_\_\_\_\_\_\_ 🞏 Pancreatitis \_\_\_\_\_\_\_\_

🞏 Blood in stool \_\_\_\_\_\_\_\_ 🞏 Constipation \_\_\_\_\_\_\_\_

🞏 Irritable Bowel Disease \_\_\_\_\_\_\_\_ 🞏 Crohn's Disease \_\_\_\_\_\_\_\_

🞏 Chronic Diarrhea\_\_\_\_\_\_\_\_ 🞏 Constipation \_\_\_\_\_\_\_

🞏 Jaundice \_\_\_\_\_\_\_\_ 🞏 Blood from rectum \_\_\_\_\_\_\_\_

🞏 Ulcer disease \_\_\_\_\_\_\_\_ 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENDOCRINAL SYSTEM

🞏 Thyroid Problems \_\_\_\_\_\_\_\_ 🞏 Diabetes \_\_\_\_\_\_\_\_

🞏 Low Sugar \_\_\_\_\_\_\_\_ 🞏 Problems with potassium \_\_\_\_\_\_\_\_

GENITAL URINARY SYSTEM

🞏 Kidney Stones \_\_\_\_\_\_\_\_ 🞏 Prostate Enlargement \_\_\_\_\_\_\_\_

🞏 Urinary Tract Infections \_\_\_\_\_\_\_\_ 🞏 Uremia Retention \_\_\_\_\_\_\_\_

🞏 Loss of urine with coughing or sneezing \_\_\_\_\_\_\_\_

EYES, EARS, NOSE, THROAT

🞏 Blurred Vision **\_\_\_\_\_\_\_\_** 🞏 Loss of Vision **\_\_\_\_\_\_\_\_**

🞏 Eye Pain \_\_\_\_\_\_\_\_ 🞏 Glaucoma \_\_\_\_\_\_\_\_

🞏 Cataract \_\_\_\_\_\_\_\_ 🞏 Cavities \_\_\_\_\_\_\_\_

🞏 Bleeding gums \_\_\_\_\_\_\_\_ 🞏 Hearing Loss \_\_\_\_\_\_\_\_

🞏 Difficulty Swallowing \_\_\_\_\_\_\_\_

SKIN

🞏 Change in pigment or mole \_\_\_\_\_\_\_\_\_ 🞏 Non-Healing sores \_\_\_\_\_\_\_\_

🞏 History of skin cancer or melanoma \_\_\_\_\_\_\_\_ 🞏 Rashes \_\_\_\_\_\_\_\_

NERVOUS SYSTEM 🞏 Weakness \_\_\_\_\_\_\_\_

🞏 Blackouts \_\_\_\_\_\_\_\_ 🞏 Multiple Sclerosis \_\_\_\_\_\_\_\_

🞏 Seizures \_\_\_\_\_\_\_\_ 🞏 Stroke \_\_\_\_\_\_\_\_

🞏 Pinched Nerves\_\_\_\_\_\_\_\_ 🞏 Headaches \_\_\_\_\_\_\_\_

MUSCULOSKELETAL SYSTEM

🞏 Arthritis \_\_\_\_\_\_\_\_ 🞏 Back Pain \_\_\_\_\_\_\_\_

🞏 Joint Pain \_\_\_\_\_\_\_\_ 🞏 Joint Swelling \_\_\_\_\_\_\_\_

🞏 Leg Ulcers \_\_\_\_\_\_\_\_

Any Additional Medical Problems Not Listed Above Mark Here:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BROKEN BONES

WHICH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHICH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHICH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEXUALLY TRANSMITTED INFECTIONS

🞏 Gonorrhea \_\_\_\_\_\_\_\_ 🞏 Syphilis \_\_\_\_\_\_\_\_

🞏 Herpes \_\_\_\_\_\_\_\_ 🞏 Chlamydia \_\_\_\_\_\_\_\_

🞏 Genital Warts \_\_\_\_\_\_\_\_ 🞏 Other(s) \_\_\_\_\_\_\_\_

If you checked any, where you treated? 🞏 YES 🞏 NO WHEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in obtaining HIV testing? 🞏 YES 🞏 NO

WHAT SURGERIES HAVE YOU HAD ?

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

Has anyone in your family ever had or do they currently have

🞏 Heart Disease \_\_\_\_\_\_\_\_ 🞏 Cancer \_\_\_\_\_\_\_\_

🞏 Other hereditary Illnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Diabetes \_\_\_\_\_\_\_\_

SOCIAL HISTORY

Do you smoke (cigarettes, pipes, and cigars) now? 🞏 YES 🞏 NO

If yes, what do you smoke and for how long have you been smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If no, have you ever smoked? 🞏 YES 🞏 NO WHEN: \_\_\_\_\_\_\_\_\_\_\_\_\_

If you do smoke, how much do you smoke? (i.e., number of cigarettes/packs per day) \_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? 🞏 YES 🞏 NO HOW MUCH? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently used or ever used? 🞏 cocaine, 🞏 marijuana, 🞏 narcotics, 🞏 I.V. drugs

HEALTH MAINTENANCE

Please Fill In APPROXIMATE DATE for the following

WHEN WAS YOUR LAST:

Lab Work \_\_\_\_\_\_\_\_ EKG \_\_\_\_\_\_\_\_ Last T.B. Test \_\_\_\_\_\_\_\_ Chest X-Ray \_\_\_\_\_\_\_\_

Colonoscopy \_\_\_\_\_\_\_\_

WOMEN: Last PAP Smear \_\_\_\_\_\_\_\_ Mammogram \_\_\_\_\_\_\_\_ DEXA (Bone) Scan \_\_\_\_\_\_\_\_

Last Menstrual Period \_\_\_\_\_\_\_\_ Do You Have A Birth Control Method? \_\_\_\_\_\_\_\_ Which? \_\_\_\_\_\_\_\_

MEN: Prostate Exam \_\_\_\_\_\_\_\_

VACCINATIONS

Insert "Date" if vaccinated, and date is known.

Write (+) if vaccinated, but date unknown.

Write date if known DATE

Influenza \_\_\_\_\_\_\_\_

Pneumococcus \_\_\_\_\_\_\_\_

Tetanus, Diptheria Toxoids (TD) \_\_\_\_\_\_\_\_

Measles (Rubeola) \_\_\_\_\_\_\_\_

Mumps \_\_\_\_\_\_\_\_

Rubella \_\_\_\_\_\_\_\_

Polio-OPV \_\_\_\_\_\_\_\_

Polio-IPV \_\_\_\_\_\_\_\_

Hepatitis A \_\_\_\_\_\_\_\_

Hepatitis B \_\_\_\_\_\_\_\_

HiB (Haemophilus) \_\_\_\_\_\_\_\_

Varicella #1 \_\_\_\_\_\_\_\_

Varicella #2 \_\_\_\_\_\_\_\_