Jeannette Painovich, DAOM, L.A.c, M.A.
13001 Seal Beach Blvd. Ste. 360
Seal Beach, CA 90740
(562)431-4120 phone (562)431-2722 fax

Patient Information

Name:_____
First Middle Last

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Sex: M F Age:_____ Date of Birth:_____

Occupation:_____ Employer:_____

Emergency
Contact:_____
Name Relationship

_____
Street City State Zip Phone

Referred By: _____

Primary Care Physician:_____

Primary Insurance: _____

Medical Records

The patient or patient's representative hereby authorizes Jeannette Painovich DAOM, L.A.c to obtain his/her medical records from current and/or previous medical history rendered by other physicians or medical centers.

_____ _____
Signature of Patient Signature of Patient Representative

CANCELLATION POLICY

There will be a $35.00 cancellation fee on all appointments cancelled less than 24 hours in advance.

_____
Signature of Patient

NAME:

MEDICAL HISTORY

Do you have any of the following:

General

Recent weight change	Yes	No
Have you been in good health most of your life?	Yes	No

Skin

Skin Disease	Yes	No
Jaundice	Yes	No
Hives, eczema or rash	Yes	No
Frequent infections or boils	Yes	No

Neck and above

Eye disease or injury	Yes	No
Do you wear glasses	Yes	No
Headaches	Yes	No
Migraines	Yes	No
Itching eyes or nose	Yes	No
Sneezing or running nose	Yes	No
Nosebleeds	Yes	No
Chronic sinus trouble	Yes	No
Ear Disease	Yes	No
Impaired hearing	Yes	No
Dizziness	Yes	No
Stiff neck	Yes	No

Respiratory

Upper respiratory infection	Yes	No
Chronic cough	Yes	No
Asthma or wheezing	Yes	No
Difficulty breathing	Yes	No
Any trouble with lungs	Yes	No
Pleurisy or pneumonia	Yes	No

Cardiovascular

Chest pains or angina	Yes	No
Shortness of breath	Yes	No
Difficulty walking two blocks	Yes	No
Heart trouble	Yes	No
High blood pressure	Yes	No
Swelling of hands, feet or ankles	Yes	No
Heart murmur	Yes	No
Palpitations, irregular heart beat	Yes	No
Rheumatic fever	Yes	No

Hematologic

Are you slow to heal after cut or bruises	Yes	No
Blood disease	Yes	No
Anemia	Yes	No
Phlebitis/blood clots	Yes	No
Problems with excessive bleeding	Yes	No

Addictive behavior

History of smoking	Yes	No
History of drug abuse	Yes	No
History of alcohol abuse	Yes	No
History of eating disorder	Yes	No

Gastrointestinal

Ulcer	Yes	No
Gallbladder disease	Yes	No
Liver trouble/hepatitis	Yes	No
Constipation	Yes	No
Bleeding with bowel movement	Yes	No
Hemorrhoids	Yes	No
Frequent diarrhea	Yes	No
Irritable Bowel Syndrome	Yes	No
Crohn's disease	Yes	No
Food stuck/difficulty swallowing	Yes	No

Genitourinary

Loss of urine or nighttime urination	Yes	No
Frequent urination	Yes	No
Straining/painful urination	Yes	No
Blood in urine	Yes	No
Kidney trouble	Yes	No
Prostrate problems	Yes	No
Difficult erection/impotence	Yes	No
Premature ejaculation	Yes	No
Infertility	Yes	No

Gynecological

Age of first period	_____	
Number of days period lasts	_____	
Average days between periods	_____	
Cramping	Yes	No
PMS	Yes	No
Number of children	_____	
Date of menopause	_____	
Hot flashes	Yes	No
Vaginal discharge	Yes	No

Locomotor/Musculoskeletal

Arthritis or joint pain	Yes	No
Weakness of muscles/joints	Yes	No
Pain in calves when walking	Yes	No
Epilepsy or convulsions	Yes	No
Varicose veins	Yes	No

Endocrine

Thyroid disease	Yes	No
Hormone therapy	Yes	No
Diabetes	Yes	No

Other

Sexually transmitted diseases	Yes	No
HIV/Aids	Yes	No
Cold sores	Yes	No

Allergies and Sensitivities (drugs of food)

_____

_____

_____

_____

Name: _____ Date:

What chief complaint brought you here?

Have you had any serious illnesses? Yes No
If yes, please explain:

Have you ever been hospitalized or under medical care for an extended period? Yes No
If yes, please explain:

Have you had any surgeries? Yes No
If yes, please list:

List of current medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Has any blood relative ever had :

Cancer	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Mental Illness	Yes	No