Physician: **Dr. S. Park**
DOS:

Patient Information

Name____
Address____
City/State/Zip____________________________________
Phone____
Driver's License__________________________________
Spouse____
Nearest Relative__________________________________
Employer_______________________________________
Address____
City/State/Zip____________________________________

Referring Physician________________________________
Family Physician__________________________________
Marriage Status: Married/Single/Divorced/Widowed
Age___ Date of Birth____________SSN_____________
Sex____ Email ___________________________________
Spouse Work Phone_______________________________
Relative Phone___________________________________
Occupation______________________________________
Work Phone______________________________________

If Patient under 18 or Lives with Parents

Father's Name____________________________________
Father's Date of Birth______________________________
Father's SSN_____________________________________
Father's Employer_________________________________
Employer Address_________________________________
City/State/Zip____________________________________
Work Phone______________________________________

Mother's Name____________________________________
Mother's Date of Birth_____________________________
Mother's SSN_____________________________________
Mother's Employer_________________________________
Employer Address_________________________________
City/State/Zip____________________________________
Work Phone______________________________________

If Patient Filing under Workers Compensation

Name of Worker's Compensation Insurance____
Address of Ins. Co.________________________________
City/State/Zip____________________________________
Current duty status_______________________________

Employer Phone___________________________________
Claim#____
Is light duty available? Yes / No

Health Insurance

How do you intend to pay for today's visit? Cash / Visa / MasterCard
Name of Responsible Party_______________________
Was this an accident? Y / N On the Job? Y / N
Which applies to you? (circle): Medicare HMO Worker's Comp PPO Private Pay Other

Primary Insurance

Insured by: Self / Spouse / Parent
Insurance Co.____________________________________
Address____
City/State/Zip____________________________________
Insurance Type: Group / Individual
Group#____
Policy#___________________Cert#_______________
Insured SSN______________________________________
Insured Date of Birth_______________________________
Medicare/Medi-Cal#_______________________________

Secondary Insurance

Insured by: Self / Spouse / Parent
Insurance Co.____________________________________
Address____
City/State/Zip____________________________________
Insurance Type: Group / Individual
Group#____
Policy#__________________Cert#_______________
Insured SSN______________________________________
Insured Date of Birth_______________________________
Medicare/Medi-Cal#_______________________________

Patient/Guardian Signature____ Date_____________________________

Patient:
Physician: Dr. S. Park
Date:

Past Medical History

Primary care physician:_________________________________ Date of last exam:_______________________

Please check if you have had any of the following:

- ☐ Childhood diseases
- ☐ Cancer
- ☐ Stomach ulcer
- ☐ Seizures
- ☐ Irregular heartbeat
- ☐ HIV/AIDS
- ☐ Colitis
- ☐ Blood transfusions
- ☐ High blood pressure
- ☐ Tuberculosis
- ☐ Psychiatric problems
- ☐ Thyroid disease
- ☐ Bleeding problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney stones
- ☐ Blood clots
- ☐ Sexually transmitted diseases
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Asthma
- ☐ Diabetes
- ☐ Alcohol abuse
- ☐ Stroke
- ☐ Drug abuse
- ☐ High cholesterol
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Broken bones
- ☐ Breast lumps
- ☐ Urinary infections
- ☐ Scoliosis
- ☐ Pneumonia
- ☐ Osteoporosis
- ☐ Leg length inequality
- ☐ Liver disease
- ☐ Gout
- ☐ Ankylosing spondylitis
- ☐ Lupus
- ☐ Rheumatic fever

Other conditions, please list:____
____

Have you had Cortisone injections? Yes / No If so, why?____
Have you taken Cortisone by mouth? Yes / No If so, why?____

History of MRSA? Yes / No If so, when?________________________________

Height_______________ Weight________________

Which pharmacy would you like to use? _________________________________

Pharmacy address:__________________________________
Pharmacy city/state/zip:______________________________

Women

Are you pregnant? (circle) Yes / No
At what age did your menstrual cycles begin? _____________

Patient Name:

Surgical History

Please list all surgeries with approximate year according to the categories listed:

Skin/Plastic ____

Eye ____

Brain ____

Ear/Nose/Throat____

Cardiovascular ____

Pulmonary ____

Abdominal ____

Female ____

Male ____

Spine ____

Joints ____

Bones ____

Other ____

Social History

Sex:_______________ Marital Status: Married / Single / Divorced / Widowed

Children: Yes / No How many?_____________________

Have you ever required blood transfusion? Yes / No Number of units:___________

Have you ever smoked? Yes / No ________ packs a day for ______ years total If quit, when?______________

Do you drink alcohol? Yes / No How many drinks per week?________

Do you take any recreational drugs? Yes / No Which drugs?____

Are you a student? Yes / No

Job description____

Ethnicity (circle one)

African American Asian Caucasian Hispanic Native American Other Decline to answer

Patient:
Physician: Dr. S. Park

Family History

Please check if any of the following occur in your family:

- ☐ Childhood diseases
- ☐ Cancer
- ☐ Stomach ulcer
- ☐ Seizures
- ☐ Irregular heartbeat
- ☐ Colitis
- ☐ Blood transfusions
- ☐ Tuberculosis
- ☐ Psychiatric problems
- ☐ Thyroid disease
- ☐ Bleeding problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney stones
- ☐ Blood clots
- ☐ Ankylosing spondylitis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Asthma
- ☐ Diabetes
- ☐ Alcohol abuse
- ☐ Stoke
- ☐ Secondhand smoke
- ☐ Drug abuse
- ☐ High blood pressure
- ☐ Endometriosis
- ☐ Broken bones
- ☐ Urinary infections
- ☐ Scoliosis
- ☐ Pneumonia
- ☐ Osteoporosis
- ☐ Leg length inequality
- ☐ Liver disease
- ☐ Gout
- ☐ Endometriosis
- ☐ Lupus
- ☐ Breast lumps
- ☐ Domestic violence

If other conditions occur in your relatives, please list:
____
____

Physician Verification:_________________________ Date:________________

Patient Name: ______________________________ Date:________________

Patient Medication Record

Patient Name:____ Today's Date:_______________________________

DRUG ALLERGIES

Medication Name	Type of Reaction

List below all of the medications you take including over-the-counter and alternative remedies.
Always bring a list of every medication you take to every medical appointment.

CURRENT MEDICATIONS

Medication Name	Dose	Route	How Often	Purpose

Patient Name:

Review of Systems

Please circle symptoms and describe symptoms (if any):

General: recent weight changes, fever, weakness, fatigue, headaches

☐No problem

Skin: rashes, eruptions, dryness, jaundice, changes in skin/hair/nails, discoloration, swelling

☐No problem

Eyes: blurred vision, double vision, burning eyes, seeing spots

☐No problem

Ears/Nose/Throat: soreness/redness of gums, hoarseness, difficulty swallowing, head colds, nasal drainage, obstruction, sinus pain, ear ache, hearing loss, hearing aids

☐No problem

Musculoskeletal: joint pain, swelling, stiffness, deformity

☐No problem

Pulmonary: difficulty breathing, asthma, bronchitis, pneumonia, shortness of breath

☐No problem

Neurological: fainting, blackouts, paralysis, memory loss, dizzy spells

☐No problem

Cardiovascular: chest pain, rheumatic fever, rapid heartbeat, leg swelling, heart valve problems, varicose veins, heart attack

☐No problem

Endocrine: fatigue, hot or cold intolerance, excessive sweating, thirst, hunger

☐No problem

Gastrointestinal: decrease in appetite, nausea, vomiting, diarrhea, constipation, heartburn, hemorrhoids, reflux, blood in stool, ulcers

☐No problem

Genitourinary: change in urinary frequency, urinary pain, blood in urine, difficulty voiding, incontinence

☐No problem

Male: hernias, testicular problems, penile problems, impotency, infertility

☐No problem

Female: vaginal discharge, pain, discomfort

☐No problem

Hematological/lymphatic: anemia, easy bruising or bleeding, swollen glands

☐No problem

Psychological: nervousness, mood swings, insomnia, nightmares, depression, irritability

☐No problem