

NAME:

DOB:

PHONE:

Please check illnesses or symptoms that you presently have or have had in the past.

HEAD, EYES, EARS, NOSE, THROAT

- BLURRED VISION
- DIZZINESS
- DOUBLE VISION
- FREQUENT HEADACHES
- MIGRAINE HEADACHES
- SINUS PROBLEMS
- PAIN BEHIND EYES
- FAINTING SPELLS
- UNCONSCIOUS SPELLS
- WEAR GLASSES
- EARACHES
- DRAINAGE FROM EARS
- DECREASE HEARING
- RINGING IN EARS
- NOSEBLEEDS
- RECURRENT HEAD COLDS
- STRANGE TASTE OR LOSS OF TASTE
- STRANGE PERSISTANT ODORS

URINARY

- BLADDER DISEASE
- DIFFICULTY STARTING STREAM
- PAIN WITH URINATION
- URINATE MORE OR LESS THAN USUAL
- LOSE URINE WITH COUGH/SNEEZE
- DISCHARGE
- BLOOD IN URINE
- KIDNEY STONES

MUSCULOSKELETAL

- JOINT PAIN
- RECURRENT BACK PAIN
- SWELLING OF JOINTS
- REDNESS OR WARMTH IN JOINTS
- TINGLING/WEAKNESS IN HANDS/FEET
- MUSCLE SPASMS
- BROKEN BONES
- TREMBLING OF ANY EXTEMITY

ENDOCRINE

- THYROID PROBLEMS
- GROWTH IN NECK OR THROAT
- BRITTLE NAILS
- DRYNESS OF SKIN OR RASHES
- INABILITY TO STAND COLD OR HEAT
- CHANGE IN HAIR TEXTURE
- DIABETES
- ABNORMAL WEIGHT GAIN OR LOSS
- TIREDNESS WITHOUT REASON
- BRUISE EASILY

CARDIAC

- ANGINA
- CHEST PAIN
- HIGH BLOOD PRESSURE
- PALPITATIONS/HEART FLUTTERING
- HEART ATTACK
- HIGH CHOLESTEROL

RESPIRATORY

- ASTHMA OR HAY FEVER
- CHRONIC COUGH
- COUGHED UP BLOOD
- NIGHT SWEATS
- SHORTNESS OF BREATH
- PNEUMONIA
- INFLUENZA
- PLEURISY

GASTROINTESTINAL

- DIFFICULTY SWALLOWING
- RECURRENT SORETHROAT
- PERSISTANT HOARSENESS
- ENLARGED GLANDS
- SORES IN MOUTH
- SORE OR BLEEDING GUMS
- BELCHING OR HEARTBURN
- NAUSEA OR VOMITING
- VOMITED BLOOD
- AVOID CERTAIN FOODS
- ABDOMINAL CRAMPING
- CHANGE IN BOWELS
- BLOOD IN STOOLS
- RECTAL PAIN
- GALLBLADDER DISEASE
- HEMORRHOIDS
- COLITIS

WOMEN ONLY

- AGE OF ONSET OF PERIODS
- IRREGULAR PERIODS
- HEAVY PERIODS
- PAINFUL PERIODS
- VAGINAL DISCHARGE/BURNING
- COMPLICATIONS WITH PREGNANCY
- ABNORMAL PAP SMEAR
- SEXUALLY TRANSMITTED DISEASE

MEN ONLY

- RASH, SORES ON PENIS OR DISCHARGE
- DISCHARGE FROM PENIS
- IMPOTENCE

NAME:

DOB:

PHONE:

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: M F
Last First Middle

Social Security #: _____

Address: _____ Home Telephone: _____
P.O. Box and Street Address

_____ Work Telephone: _____
City State Zip

Marital Status (check one): Minor Single Married Divorced Widowed Separated

Driver's License #: _____ State Issued: _____ E-Mail address: _____

Patient/Parent's Employer Name & Address: _____

Insured's Employer Name and Address: _____

Emergency Contact Information:

Name of Emergency Contact: _____ Relation to Patient: _____
Last First Middle

Address: _____ Home Telephone: _____
P.O. Box and Street Address

_____ Work Telephone: _____
City State Zip

Responsible Party Information (for Minors):

Name of Responsible Party: _____ Relation to Patient: _____
Last First Middle

Address: _____ Home Telephone: _____
P.O. Box and Street Address

_____ Work Telephone: _____
City State Zip

Social Security #: _____ Driver's License #: _____ State Issued: _____

Insurance Information:

Primary Insurance Co: _____ Policy #: _____

Insured's Name: _____ Effective Date: _____

Secondary Insurance Co: _____ Policy #: _____

Insured's Name: _____ Effective Date: _____

Tertiary Insurance Co: _____ Policy #: _____

Insured's Name: _____ Effective Date: _____

I authorize the release of any medical information necessary to process my insurance claim and request payment of government benefits either to myself or to the party who accepts assignment. I also authorize payment of medical benefits to physician/provider for services rendered pursuant to filing insurance claim. I authorize representatives of Grayson Highlands Family Medicine to leave messages with family members or messages on home answering machines concerning lab results and appointment reminders. I authorize the collection of blood samples for testing for Hepatitis, HIV and other bloodborne pathogens in the event of an accidental needle stick injury.

I agree that these provisions will remain in effect until I provide written revocation to Grayson Highlands Family Medicine.

Patient or Parent's Signature (SEAL)

Date