

Patient Information Record

(Please Print)

Today's Date:		PCP:	
PATIENT INFORMATION			
Patient Name:		Date of Birth:	Age:
Marital Status: (circle one) Single Married Widowed Separated Divorced			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			Home Phone: ()
City:	State:	Zip:	Cell Phone: ()
Employed by:			Occupation:
Business Address:			Email:
Business Phone: ()	Driver's License #:		Social Security #:
Referred by:			Phone #:
SPOUSE/PARENT INFORMATION			
Parent/Spouse Name:			Social Security #:
Birth Date:	Cell Phone: ()		Drivers License #:
Employed by:			Occupation:
Business Address:		City:	State: Zip:
Business Phone: ()		Ext.:	Email:
IN CASE OF EMERGENCY			
Friend	Name:		Phone #:
	Address:		City: State
Nearest Relative (Not Spouse)	Name:		Phone #:
	Address:		City: State:
INSURANCE INFORMATION			
Do you have medical insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Deductibles: Co-Pay:
Primary Insurance Company:		Address:	
Member ID:	Group #:	Insured Name:	
Secondary Insurance Company:		Address:	
Member ID:	Group #:	Insured Name:	
Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Medical? <input type="checkbox"/> Yes <input type="checkbox"/> No
RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS			
<p>The above information is true to the best of my knowledge. I hereby authorize Dr. Kedy Y. Jao to disclose, when requested by the above named insurance carrier or its representatives, any and all information with respect to any illness (es), medical history or treatment and copies of all medical records. A photo static copy of this authorization shall be considered as effective and valid as the original. I hereby authorize payment directly to Dr. Kedy Y. Jao of the surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for all charges not covered by this authorization and I further agree in the event of non-payment, to bear the cost of reasonable legal fees should it be required.</p>			
Date:	Print Name (patient or parent if minor):	Signature:	
Please provide your insurance card and driver's license to the receptionist			

FAMILY HISTORY

	Age	State of Health	Has any blood relative had:	who?
Father	_____	_____	_____ Heart Disease?	_____
Mother	_____	_____	_____ Stroke?	_____
Brother/Sister :()	_____	_____	_____ High Blood Pressure?	_____
1. _____	_____	_____	_____ Diabetes?	_____
2. _____	_____	_____	_____ Cancer?	_____
3. _____	_____	_____	_____ Tuberculosis?	_____
4. _____	_____	_____	_____ Epilepsy?	_____
Husband/Wife:	_____	_____	_____ Insanity?	_____
Son/Daughter	_____	_____	_____ Suicide?	_____
1. _____	_____	_____	_____ Other? (What)	_____
2. _____	_____	_____		
3. _____	_____	_____		

REVIEW OF SYSTEMS:

Do you now or have you ever had?

- | | |
|---|---|
| <input type="checkbox"/> Eye disease, injury, impaired sight
<input type="checkbox"/> Wear glasses
<input type="checkbox"/> Ear disease, injury, impaired hearing
<input type="checkbox"/> Difficulties in nose, sinuses, or mouth
<input type="checkbox"/> Dental problem
<input type="checkbox"/> Wear dentures
<input type="checkbox"/> Enlarged glands
<input type="checkbox"/> Enlarged thyroid or goiter
<input type="checkbox"/> Chronic or frequent cough
<input type="checkbox"/> Pain on taking a breath
<input type="checkbox"/> Chest pain at rest
<input type="checkbox"/> Chest pain on exertion or movement
<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Palpations or fluttering of heart
<input type="checkbox"/> Extreme tiredness or weakness
<input type="checkbox"/> Swelling of ankles
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Muscle aches | <input type="checkbox"/> Pain in abdomen or stomach
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Light or white stool
<input type="checkbox"/> Black stool or bleeding from rectum
<input type="checkbox"/> Mucus in stool
<input type="checkbox"/> Colitis or other bowel disease
<input type="checkbox"/> Jaundice or yellow skin
<input type="checkbox"/> Pain on urinating
<input type="checkbox"/> Difficulty in urination
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Bleeding with urination
<input type="checkbox"/> Light-headedness or dizziness
<input type="checkbox"/> Black out spell
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Paralysis or muscle weakness
<input type="checkbox"/> Frequent or severe headaches
<input type="checkbox"/> Depression or anxiety
<input type="checkbox"/> Skin disease
<input type="checkbox"/> Arthritis, joint swelling or stiffness |
|---|---|

FOR WOMEN ONLY

Age when menstruation began _____	Number of children born alive _____
Regular: <input type="checkbox"/> Yes <input type="checkbox"/> No	If any of the following how many?
Usual length of period _____	Cesarean Sections: _____
Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light	Children stillborn: _____
Pain or cramping <input type="checkbox"/> Sever <input type="checkbox"/> Light <input type="checkbox"/> None	Premature deliveries: _____
Cycle (start to start) _____	At what month? _____
Date of last period _____	Miscarriages (less than 4 mo) _____
Describe any complications with pregnancy _____	

DISCLAIMER

"I the undersigned understand and agree that DR. KEDY JAO, D.O., and her employees and agents assume no liability or responsibility for the accuracy Or completeness of any information contained herein or of the omission of any information not contained herein, nor shall any of the foregoing parties be held liable or otherwise responsible for the denial of medical treatment, results of medical treatment, or the actions of any physician, hospital, clinic, Institution, medical personnel or other person."

"I represent that I have supplied the information contained herein, that I have thoroughly reviewed this four pages history of my personal medical data , and that I take full responsibility for the accuracy, completeness and periodic updating of all information contained herein."

DATE

SIGNATURE

MEDICAL HISTORY

NAME _____ DATE _____

MARITAL STATUS (circle one) S M W D SEP AGE _____ BIRTHDATE _____

OCCUPATION _____ Who referred you to this office _____

PAST HISTOR (check one)

MEDICAL

- | | |
|--|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> German measles | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Kidney disease, Stones |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Pneuothorax | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hives, Eczema |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Anemia, Bleeding |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Cancer |

Operation:	Hospitalization:	Age:	Reason:	Doctor:	Hospital:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Injuries:	Age:	Description:
Fractures, Dislocations	_____	_____
Concussion, Head Injuries	_____	_____
Other injuries	_____	_____

ALLERGIES: Have you ever had an allergic reaction to:

	Yes	No		Yes	No
Penicillin	_____	_____	Any Foods (which)	_____	_____
Sulfa	_____	_____	Adhesive Tape	_____	_____
Procaine, Anesthesia	_____	_____	Nail Polish, Cosmetics	_____	_____
Bee or other Stings	_____	_____	Tetanus, Other Injections (what)	_____	_____
Others _____	_____	_____			

Alcoholic beverages

_____ Never _____ Rarely _____ Moderately _____ Daily

Tobacco:

Cigarettes per day _____ Cigars per day _____ Pipe bowls per day _____

How long ago did you stop? _____

Has your work ever exposed you to irritating fumes or dusts? (What and when?) _____

Weight: Now _____ One year ago _____ Most you weigh _____ At age _____

Medicines you take now, including dosage: _____