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# New Patient Health and History Form

*(please print and use black ink only)*

## Patient Registration Details

Date:_____ Referred By:_____

Name: (Last)_____ (First)_____ (M)_____
Date of Birth:_____ Age:_____ F_____ M_____
Address:_____
City:_____ State:_____ Zip:_____
Home Ph:_____ Work Ph:_____
Cell:_____ Email:_____

## Emergency Contacts

Name:_____ Relation:_____
Address:_____ Phone:_____

Name:_____ Relation:_____
Address:_____ Phone:_____

## Employment

Employer:_____ Phone:_____
Job Title:_____ Work at Home:____ Outside of Home:____
Retired:____

## Education

High School:_____ College:_____ Grad School:_____ Prof. School:_____ Military:_____

**Medical History**

Main Reason for Visit:_____

_____

_____

History of Current Health Concern:

Start Date:_____ Symptoms:_____

How Long:_____ Seek Medical Attention: Yes_____ No_____

Treatment-Care Received:_____

_____

_____

Previous Health Concern:

Start Date:_____ Symptoms:_____

How Long:_____ Seek Medical Attention: Yes_____ No_____

Treatment-Care Received:_____

_____

_____

Hospitalization (*please list date, reason, and hospital*)

_____

_____

_____

_____

**All Current Medications:**

Name:_____ Strength:_____ Dose:_____

Name:_____ Strength:_____ Dose:_____

Name:_____ Strength:_____ Dose:_____

Name:_____ Strength:_____ Dose:_____

**All Past Medications:**

Name:_____ Strength:_____ Dose:_____
Name:_____ Strength:_____ Dose:_____
Name:_____ Strength:_____ Dose:_____
Name:_____ Strength:_____ Dose:_____

**Current Vitamins-Herbs-Remedies:**

Name:_____ Strength:_____ Dose:_____
Name:_____ Strength:_____ Dose:_____
Name:_____ Strength:_____ Dose:_____
Name:_____ Strength:_____ Dose:_____

**History of Allergy (*please list any Drug, Airborne, Food, and/or Chemicals*)**

_____
_____
_____
_____
_____

Any E.R. Visits: Y_____ N_____

Treatment: _____
_____
_____

**Personal History *(check all that apply)***

AIDS____ Allergies____ Anemia____ Anxiety____ Arthritis____ Asthma____ Bowel Issue___
Bronchitis____ Cancer____ Chronic Fatigue____ Depression____ Diabetes____ Epilepsy____
Gallbladder____ Glaucoma____ Gout____ Headache____ Heart Attack____ Heart Other____
Hepatitis____ Auto-Immune Disease____ Kidney Disease/Stones____ Liver Disease____
Lung Disease____ Lupus____ Mental Illness____ Menopause____ Migraines____
Osteoporosis____ Pneumonia____ Prostate Disease____ Rashes____ Seizures____ STD____
Sinus____ Stomach Problems____ Stroke____ Thyroid Disease____ Ulcer____

Other:_____
_____

**Family History (*check all that apply*)**

AIDS____ Allergies____ Anemia____ Anxiety____ Arthritis____ Asthma____ Bowel Issue___
Bronchitis____ Cancer____ Chronic Fatigue____ Depression____ Diabetes____ Epilepsy____
Gallbladder____ Glaucoma____ Gout____ Headache____ Heart Attack____ Heart Other____
Hepatitis____ Auto-Immune Disease____ Kidney Disease/Stones____ Liver Disease____
Lung Disease____ Lupus____ Mental Illness____ Menopause____ Migraines____
Osteoporosis____ Pneumonia____ Prostate Disease____ Rashes____ Seizures____ STD____
Sinus____ Stomach Problems____ Stroke____ Thyroid Disease____ Ulcer____

Other:_____
_____
_____

**Travel History (*please list any places you've visited with any illnesses associated with travel*)**

_____
_____
_____
_____

**Women (*check all that apply*)**

Pregnant now_____ Trying to get Pregnant_____ Planning a Pregnancy_____
Menstruation: Age Started_____ Length of period_____
Irregular:Y___ N___ Heavy Bleeding:Y___ N___ PMS:Y___ N___ Cramps:Y___ N___
Menopause: Date Started_____ Medication_____ Bleeding/Spotting_____
Birth Control Method:_____ # of Live Births_____ # of Still Births_____
Abortions_____ Miscarriages_____ Last Delivery_____

**History of Sexual Activity (*check all that apply*)**

Sexually Active:Y____ N____ Multiple Partners:Y____ N____ Same-Sex Partner:Y____ N____
Enjoy Intercourse:Y____ N____ Pain During Intercourse:Y____ N____ Pain After:Y____ N____
Yeast Infections:Y____ N____ Bladder Infections:Y____ N____ Herpes:Y____ N____
Chlamydia:Y____ N____ Other STD:Y____ N____ Pelvic Inflammatory Disease:Y____ N____

**Environment**

Work: (hours; exposure to noise, temperature, chemicals, stress, other)

_____
_____
_____
_____

Home: (type of home; indoor air quality; exposure to noise, temperature, chemicals, stress, other)

_____
_____
_____
_____

**Describe Diet (what you normally eat in a day)**

Breakfast: _____
_____
_____
_____

Lunch: _____
_____
_____
_____

Dinner: _____
_____
_____
_____

**Describe Exercise and/or Recreation:**

_____
_____
_____
_____

# Financial - Insurance Information and Agreement

*(please read through carefully and provide all necessary information)*

## Medicare Patients:

Dr. Howard does not participate in Medicare so you will need to sign a separate Medicare Contract Form (please inform us). Payment is required at time of service.

## Insured Patients:

We do not participate in any insurance plans so payment is required at time of service. However, you may submit Dr. Howard's superbill to your insurance company for any reimbursements.

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## Missed Appointment and/or Last Minute Cancellation:

If you miss or cancel an appointment with less than 24 hours prior notice, you will be charged 50% of the visit.* **Exceptions: illness, work, or childcare*

Please provide the requested credit card information below:

**Credit Card #:** _____ **Exp. Date:** _____

*(Accepted Cards : Visa, MC, Discover)*

By signing below, you are confirming that you have read and are in agreement with our policy. Thank you for your cooperation.

**Signature:** _____ **Today's Date:** _____