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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.

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:** _____