Windsor Regional Medical Associates, LLC

PATIENT HISTORY

Name ______________________ Date of Birth __________ Date __________

Reason for today's visit ______________________

Prior/Other doctors you see ______________________

MEDICATIONS

List All Prescription AND non-prescription medications / supplements that you are taking

Drug	Drug Strength	Frequency

PAST MEDICAL HISTORY (Check all that apply to you)

Eyes/Ears/Nose: ☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Hearing Loss ☐ Nasal Allergies

Vascular: ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Diseases of the Veins ☐ Rheumatic Fever - Murmur

Respiratory: ☐ Asthma ☐ Tuberculosis/Positive TB test ☐ Emphysema/COPD ☐ Pneumonia

GI tract: ☐ Gallstones ☐ Hepatitis ☐ Ulcers ☐ Acid Reflux Disease ☐ Rectal Bleeding ☐ Colon Polyps ☐ Diverticulitis

Urinary: ☐ Frequent Urinary Infections ☐ Kidney Stones ☐ Kidney Disease

Reproductive: ☐ STD ☐ Infertility ☐ Enlarged Prostate ☐ Erectile Dysfunction ☐ Irregular Periods

Endocrine: ☐ Diabetes ☐ High Cholesterol/Triglycerides ☐ Gland Disorder (thyroid, pituitary, adrenal, parathyroid)

Joints: ☐ Osteoporosis ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Lupus ☐ Gout ☐ Psoriasis

Blood/Oncology: ☐ Cancer ☐ Anemia ☐ Blood Transfusion ☐ Bleeding Disorder ☐ DVT or clots

Nervous: ☐ Frequent Headaches ☐ Psychiatric Illness ☐ Depression ☐ Anxiety

Gynecology: # Pregnancies ______ # Deliveries ______ Date of last period __________

Other (Please describe) ______________________

***** LIST FOOD AND DRUG ALLERGIES *** or write 'none'**

Surgeries (date, type, hospital)

Hospitalizations (date, type, hospital) and Serious Illnesses

FAMILY HISTORY

Family Member	Status	Age	Diseases (e.g. cancer, heart disease, diabetes)
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Brothers/Sisters(age/health)			
Children(age/health)			

SOCIAL HISTORY (Circle Yes or No and fill in appropriate blank)

- Smoking ______ Packs/Day ______ Years ______
- Recreational Drug Use ______ Drugs Used ______
- Exercise (Type/Frequency) ______
- Caffeine on a regular basis ______ Cups/Day ______
- Alcohol Intake ______
- Sexually Active ______ Number of Active Partners ______ Past Partners ______
- Have you traveled outside the US in the past 6 months? ______ Where? ______
- Occupation ______ Hazardous Exposures ______

HEALTH SCREENING (write year last done)

Cholesterol ______ Bone Density ______ Blood Sugar______ Blood Pressure Exam ______

Mammogram ______ Pap Smear ______ Colonoscopy ______ Chest X-ray ______ EKG______

Stress Test ______ Rectal Exam ______ Dentist ______ Eye Doctor ______

IMMUNIZATIONS (write year vaccine was given)

Pneumonia ______ Flu ______ Tetanus ______Hepatitis B ______ Meningitis ______ Gardasil ______

REVIEW OF SYMPTOMS (**Check** any symptoms you have experienced recently)

GENERAL: ☐ weight gain ☐ loss of appetite ☐ fever ☐ weakness ☐ weight loss ☐ night sweats

HEAD: ☐ cold ☐ cough ☐ coughing blood ☐ nose bleed ☐ hearing loss ☐ change in voice ☐ sore throat ☐ ringing in ears ☐ snoring

EYES: ☐ diminished vision ☐ eye irritation ☐ drainage from eyes ☐ blurred vision ☐ allergic eyes ☐ loss of vision

ENDOCRINE: ☐ fatigue ☐ excessive sweating ☐ excessive thirst ☐ excessive urination ☐ weight loss ☐ cold intolerance ☐ heat intolerance

ALLERGY: ☐ runny nose ☐ scratchy throat ☐ itchy eyes ☐ ear fullness ☐ sinus congestion ☐ stuffy nose

HEART: ☐ chest pain ☐ palpitations ☐ leg swelling ☐ dizziness

LUNGS: ☐ shortness of breath ☐ chest pain ☐ chest congestion

DIGESTIVE: ☐ nausea ☐ heartburn ☐ stool incontinence ☐ vomiting ☐ bloating/belching ☐ blood in stool ☐ difficulty swallowing ☐ abdominal pain ☐ diarrhea ☐ constipation ☐ change in bowel habits

URINARY: ☐ difficulty urinating ☐ blood in urine ☐ urinary urgency ☐ frequent urination ☐ urinary incontinence ☐ genital pain ☐ painful intercourse ☐ recurrent UTI ☐ nightime urination

SKIN: ☐ rash ☐ change in moles ☐ lumps ☐ dry/sensitive skin ☐ hives

NERVOUS: ☐ headache ☐ tingling/numbness ☐ seizures ☐ insomnia ☐ memory loss ☐ dizziness - vertigo

BLOOD/GLANDS: ☐ swollen gland ☐ loss of appetite ☐ varicose veins ☐ easy bruising

SKELETAL: ☐ joint swelling ☐ joint pain ☐ muscle cramps ☐ muscle pains ☐ joint stiffness ☐ trouble walking

PSYCHIATRIC: ☐ high stress level ☐ depression ☐ sleep disturbances ☐ overwhelming sense of panic ☐ suicidal thoughts ☐ eating disorder ☐ mental/physical abuse

MALE: ☐ difficulty with erection ☐ difficulty with ejaculation ☐ diminished sexual drive ☐ abnormal discharge

FEMALE: ☐ heavy periods ☐ pain with intercourse ☐ premenstrual moodiness ☐ pain with menses - infertility ☐ yeast infections ☐ vaginal itching ☐ irregular bleeding ☐ irregular periods ☐ abnormal discharge ☐ hot flashes ☐ nipple discharge ☐ breast lump

Windsor Regional Medical Associates, LLC

Patient Information

Last Name ______________________ First Name ______________________
Street Address ______________________ City ______________ State _____ Zip ________
Home Phone ______________ SS # ______________ Date of Birth ____________

Work Phone ______________________ Cell Phone ______________________
Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Emergency Contact ______________________ Relationship __________ Phone ______________
If you would like to receive our quarterly newsletter, e-mail address: ______________________
How did you choose our office ______________________

May we leave messages for you at your home? ☐ Yes ☐ No
May we leave messages for you at work? ☐ Yes ☐ No

Pharmacy ______________ Location ______________ Phone ______________
Spouses Name ______________________ Spouses Work Phone ______________________
Do you have an advanced directive or living will? ☐ Yes ☐ No

Employment Information

Employed ☐ Full Time ☐ Part Time ☐ Retired Employer Name ______________________
Street Address ______________________ City ______________ State ____ Zip ________
Phone ______________________ Occupation ______________________

Guarantor Information (Responsible Party for Bills) - If OTHER than Self

Guarantor's Name ______________________ Relationship to Patient: ☐ Spouse ☐ Child ☐ Other

If Child or Other - Please specify relationship of Other ______________ and fill out the following information
Street Address ______________________ City ______________ State ______ Zip ________
Date of Birth ______________________ SS # ______________________

Home Phone ______________________ Work Phone ______________________

Primary Insurance

Primary Insurance Name ______________________ Insured Person's Name ______________________

Relationship to Patient ☐ Self ☐ Spouse ☐ Other Insured Date of Birth ______________
Policy # ______________________ Group # ______________________

Secondary Insurance

Secondary Insurance Name ______________________ Insured Name ______________________

Relationship to Patient ☐ Self ☐ Spouse ☐ Other Insured Date of Birth ______________
Policy # ______________________ Group # ______________________

Release of Records

I authorize the release of my medical information to the following other people: (write names or 'none')

____

If no one is listed, records will only be released to you or as required by law. **Please consider** if you wish to allow family members any access to you information when completing this section.

Patient's Payment Responsibility

I understand that I am financially responsible for all charges for all medical bills incurred while under the care of Windsor Regional Medical Associates, LLC including the balance remaining after payment of possible insurance benefits. In the event that my account is not paid, I shall be liable for any and all costs of collection, including but not limited to a fee of 40% of my unpaid balance if my account is forwarded to a collection agency. I further understand that there will be a $10 per month service fee if my unpaid account balance is more than 30 days overdue. I understand that there will be a $20 service charge for any checks returned for insufficient funds. I understand that canceling a scheduled appointment with less than 24 hours notice or failing to show for a scheduled appointment in a timely manner may result in a cancellation fee of $50 per occurrence. My signature below indicates that I have read and understand the above terms and conditions.

Signed (Patient or Parent if Minor) ____ Date ____________________

Assignment of Benefits

I authorize payment of medical benefits directly to Windsor Regional Medical Associates, LLC on my behalf for all professional services rendered. I authorize Windsor Regional Medical Associates, LLC to submit claims to Medicare and/or other medical insurance carriers on my behalf. My refusal to sign indicates that I will be responsible for all charges I incur at the time services are rendered, and must seek third-party reimbursement independently. I further authorize that photocopies shall be valid as originals.

Signed ____ Date __________________________

Release of Information

I authorize the release of any medical information necessary to process this claim or as required by law.

Signed ____ Date __________________________

Receipt of Notice of Privacy Practices

I have received a copy of the Windsor Regional Medical Associates' Notice of Privacy Practices.

Signed ____ Date __________________________

After forms completed click 'print form' above and be sure to sign & date the four lines on this page. Bring the completed forms to your first visit. Please note the free version of Adobe Acrobat **Reader** is unable to save your responses to a file, so please don't forget to print them when done. Please do not attempt to email or fax the forms.