Atlas Medical Center

Patient Information

Today's Date: _____
Patient's FULL Legal Name_____
Last *MI* *First*
Preferred Name_____ ☐Male ☐Female Birth date _____
Height: _____ Weight: _____

SSN_____ ☐Minor ☐Single ☐Married ☐Divorced
Address_____
City _____ State _____ Zip_____
E-Mail _____ Phone_____

Employer_____ Phone _____
Address _____City _____ State _____ Zip _____
If student, name of school/college _____

Spouse or Parent/Guardian's name_____
Whom may we thank for referring you? _____

Treating Physician _____ Phone _____
Do we have permission to discuss your condition with them? ☐ Yes ☐ No

Emergency Contact _____ Phone _____
In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____
Parent or Guardian Signature Date

Responsible Party _____ Relationship to Patient _____
Address _____ Phone _____
E-Mail _____
SSN _____ Birth date _____
Employer _____ Phone_____

Insurance Company _____ ID #_____
Claims Address_____
City _____ State _____ Zip_____
Name of Insured_____ Relationship to patient _____
Birth date _____ SSN_____
Employer_____ Work Phone _____
Address of Employer_____ State _____Zip_____

X_____ _____
Signature of Patient or parent/guardian of minor Date

Atlas Medical Center

Patient Information

Patient Name: _____DOB: _____

Health History

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(On a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this Pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____
_____
(What other associated problems have you been having?)

Modifying Factors _____
_____
(What makes the pain/problem worse or better?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no" leave blank if you are uncertain.)

Measles…… NO YES	Anemia…….. NO YES	Back Trouble……NO YES
Hepatitis…… NO YES	Mumps……. NO YES	Bladder infection…… NO YES
Ulcer…… NO YES	Diabetes……..NO YES	Kidney Disease…… NO YES
Chicken Pox…… NO YES	Epilepsy……NO YES	Thyroid Disease…… NO YES
Whooping Cough…NO YES	Migraine Headaches. NO YES	Hemorrhoids…….. NO YES
Scarlet Fever……. NO YES	Tuberculosis……..NO YES	Date of Last chest X-Ray_____
Diphtheria…… NO YES	Asthma…… NO YES	Bleeding Tendency… NO YES
Small pox…….. NO YES	Cancer…… NO YES	Hives of Eczema…….NO YES
Pneumonia…….. NO YES	Polio……NO YES	AIDS & HIV…… NO YES
Rheumatic Fever… NO YES	Glaucoma……NO YES	Infectious Mono…….NO YES
High Blood Pressure.. NO YES	Arthritis…… NO YES	Bronchitis……NO YES
Low Blood pressure… NO YES	Hernia……NO YES	Venereal Disease… NO YES

Mitral Valve Prolepses….NO YES Blood or Plasma Transfusion……..NO YES

Stroke……NO YES Any Other Disease…….NO YES (Please List): _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include non-prescription)

_____
_____
_____

Allergies to medications and/or local anesthetic	**Reaction**
_____	_____
_____	_____
_____	_____

Patient Social History:

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ I want help to quit

Use of Drugs ☐ Never Type/Frequency: _____

Exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____

Atlas Medical Center

Patient Information

Patients name:_____ DOB _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain Between Shoulder Blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

_____ _____
Signature of Doctor Date