Plaza Medical and Diagnostic, P.C.

752 Park Avenue · Huntington, NY 11743 (P)631-385-0207 (F)631-385-1272

MEDICAL HISTORY *Date:*

Name:______________________________ **Age**: ________ **Birth date**: ____________________

Address: ______________________________ **Social Security #**: ____________________ **Sex**: _____

______________________________ **Home Phone**: ____________________

How did you hear about us? ____________________ **Cell Phone**: ____________________

Referring Doctor: ____________________ Address: ______________________________ Tel________________

Primary Doctor: ____________________ Address: ______________________________ Tel________________

Dentist: ____________________ Address: ______________________________ Tel: ________________

Occupation: ______________________________ **Work Phone**: ____________________

Address: ______________________________ **E-Mail**: ____________________

( ) Single ( ) Married ( ) Divorced ( ) Widowed **Emergency Contact**:____________________

If Married, Spouse's name: Children's ages: **Telephone #**:

CHIEF COMPLAINT*:* ______________________________

Is this problem a result of an ***auto related*** injury?: ( ) No ( ) Yes: ____________________ Claim #: ____________________

If Yes, Insurance Carrier Name: Telephone #:

Is this problem a result of an ***work related*** injury?: ( ) No ( ) Yes: ____________________ Claim #:____________________

If Yes, Insurance carrier Name: Telephone #:

Allergies to medications, X-Ray Dyes or other substances: ( ) Yes ( ) No If yes, please list name(s) of medications and type of reaction:______________________________

**** Do you have a pacemaker or other cardiac device?** ( ) Yes ( ) No

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS*:*

Please circle if you have had problems with or are presently have any of the following:

1. Low back problem
2. Arthritis
3. Headache
4. Arm pain
5. Leg pain
6. Failed spinal surgery
7. Disc herniation
8. Head or neck pain
9. COPD
10. Emphysema
11. Shortness of breath
12. Asthma
13. Abdominal discomfort
14. Diabetes
15. High cholesterol
16. Heart disease
17. Sudden weight loss/gain
18. High blood pressure
19. Constipation
20. Diarrhea
21. Indigestion
22. Colitis
23. Change in bowel habits
24. Cancer
25. Chest pain/tightness
26. Swollen ankles
27. Palpitations
28. Lightheadedness
29. Frequent urination
30. Rheumatic fever
31. Bronchitis
32. Pneumonia
33. Persistent cough
34. T.B.
35. Hay fever
36. Nausea
37. Vomiting
38. Blood in stool
39. Ulcers
40. Hemorrhoids
41. Gall bladder disease
42. Hepatitis and jaundice
43. Kidney disease
44. Kidney stones
45. Thyroid disease
46. Difficulty urinating
47. Skin diseases
48. Blood disorders
49. Venereal disease
50. Anxiety
51. Depression
52. Anemia
53. Alcohol abuse
54. Drug abuse
55. Gout

Do you or your partner have:

56. Diminished sex drive
57. Memory lapses
58. Congestive heart failure
59. Morning tiredness
60. Daytime sleepy feeling
61. Problematic snoring
62. Morning headaches
63. Previous stroke
64. Previous TIA

GYNECOLOGIC & OBSTETRIC HISTORY (if female)

Age of onset periods:____________ Menses(how often):____________ Last menstrual period: ____________________

Pregnancies: ___________ Births: _________ Length of periods:_________________ Miscarriages:____________________

Prolonged or abnormal bleeding: ( ) No ( ) Yes If yes, please describe:____

Leakage of urine: ( ) No ( ) Yes If yes, please describe:____

Pelvic pain: ( ) No ( ) Yes If yes, please describe:

Please list dates of:

Operations: ____ ____

____ ____

Hospitalizations, other than surgery:

____ ____

Have you had: (Indicate last date)

Pneumovax immunization? ( ) No ( ) Yes When?______________________________

Hepatitis B vaccination? ( ) No ( ) Yes When?______________________________

Flu immunization? ( ) No ( ) Yes When?______________________________

Tetanus immunization? ( ) No ( ) Yes When?______________________________

Please indicate when you last had the following and circle whether result was normal or abnormal (N/Abn):

Pap smear?_________(N/Abn) Breast exam?_________(N/Abn) Stool check for blood?_________(N/Abn)

Mammogram?______(N/Abn) Cholesterol check?_____(N/Abn) Prostate exam?______________(N/Abn)

PPD (TB Skin Test)? (N/Abn)

FAMILY HISTORY

Has any member of you family (including parents, grandparents and siblings) ever had the following?

	Which Family Member?	**Approximate Age Diagnosed?**
Cancer (describe type)	____________________	__________
Heart disease	____________________	__________
Diabetes	____________________	__________
Stroke	____________________	__________
Mental disease (anxiety,	____________________	__________
depression, etc.)	____________________	__________
Drug or alcohol addiction	____________________	__________
Glaucoma	____________________	__________
Bleeding diseases	____________________	__________
Other:__________________	____________________	__________

MEDICATIONS (Prescription, Over-the-counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose
____________________	______________	____________________	______________
____________________	______________	____________________	______________

Assignment of benefits/authorization for treatment

I have read the above and certify that all data is accurate and true. I authorize this office to release any information on this patient that is necessary to expedite/support any insurance claims. Insurance will be accepted as payment in full where procedure is covered by insurance. Patient is responsible for notification of insurance changes before the procedure or he/she will be responsible for full payment. I authorize payment of benefits otherwise payable to me directly to this provider. Should payment be made directly to me, I hereby agree to sign over that check or I will be responsible for the entire bill. Medicare regulations may apply. I agree that in the event the account is referred to collection, I will be responsible for reasonable attorney's fees and related expenses of collection.

PATIENT____ DATE____________________

OR AUTHORIZED REPRESENTATIVE____ DATE____________________