



PLEASE PRINT THE FOLLOWING INFORMATION

PATIENT NAME: _____ D.O.B. _____ SEX: M or F

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

HEIGHT: _____ inches WEIGHT: _____ lbs. CELL PHONE #: _____

SSN: _____ - _____ - _____ DRIVER'S LIC#: _____ AGE: _____

EMAIL ADDRESS: _____ FAX: _____

ALTERNATIVE ADDRESS/HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYEE: _____ PHONE: _____

MAILING ADDRESS: (Same as above) _____

CITY: _____ STATE: _____ ZIP: _____

WHOM TO NOTIFY IN CASE OF EMERGENCY:

NAME: _____ RELATION: _____ PHONE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP: _____

INSURED NAME: _____ INSURED D.O.B.: _____

SECONDARY INSURANCE: _____

MAILING ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY #: _____ GROUP: _____

INSURED NAME: _____ INSURED D.O.B.: _____

** I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS INSURANCE CLAIMS.
** I FURTHER AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO "LIFE FAMILY PRACTICE CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE" IN THE EVENT THAT THEY FILE AN INSURANCE CLAIM.
** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID IN FULL OR PARTIALLY PAID BY THE INSURANCE CARRIER.

SIGNATURE: _____ DATE: _____

REFERRAL SOURCE: _____



1507 US Hwy 441 North, The Villages, FL 32159
Phone: 352-750-4333 | Fax: 352-750-2023

Records Release Authorization

I, _____, (print clearly) specifically authorize Life Family Practice Center to request my protected health information from the specialist or medical practice named below for the purposes of treatment and health care operations.

Description of the information to be used or disclosed (check all that apply):

- [] Any and all Records* [] Diagnostic Reports Only [] Lab Results Only [] Immunizations
[] Chart Notes Only [] Consultations Only [] Other

*May not include mental health treatment records, psychological services and social services information, including communications made by patient to a social worker or psychologist.

*May not include communicable disease and infection information (which include venereal disease "VD", tuberculosis "TB", Hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC").

*May not include alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.

Name of the specialist or other medical practice, address, and fax number:

Life Family Practice Center shall send information ONLY to the above address and /or fax number. Any disclosure of the patient's protected health information to another address or fax number will require a separate authorization.

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Life Family Practice Center must receive the revocation in writing with my signature.

This authorization shall expire on _____. After this date Life Family Practice Center can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient's Signature

Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____.



HEALTH QUESTIONNAIRE

NOTE: Read carefully – fill in or circle information as completely as possible. The information provided by this questionnaire will become a permanent part of your records at our Center.

NAME & ADDRESS OF YOUR PHYSICIAN (MD, DO, OR DC)

DATE OF LAST CONSULTATION WITH FAMILY PHISICIAN

DEMOGRAPHIC BACKGROUND

MARITAL STATUS: MARRIED SINGLE DIVORCED: How Long? _____ WIDOWED: How Long? _____

NUMBER OF MARRIAGES: _____ NUMBER OF CHILDREN? _____

Adult Children's Name	Address	Phone

List additional children's names, addresses and phone at the back or on a separate paper

WORK TYPE:

WORK STATUS: FULLTIME PART TIME RETIRED If retired, how long? _____

ALCOHOL USE: NO YES TOBACCO USE: NO YES

If alcohol quit, how long ago? If tobacco quit, how long ago?

If current, how much and how long? If current, how much and how long?

MAJOR COMPLAINTS AND HOW LONG THEY HAVE BEEN PRESENT, i.e., HEART DISEASE x 10 OR KIDNEY DISEASE x 5 YEARS

IN YOUR OWN WORDS DESCRIBE YOUR MOST PERSISTENT MEDICAL PROBLEM WITH SYMPTOMS, THEIR DURATION AND RESPONSE TO PREVIOUS TREATMENTS: (Can use the back page or separate paper.)

Reviewed by Physician: _____ (Initials) Review Date: _____

ILLNESSES AND MEDICAL PROBLEMS

Check problems you have or have had that have been diagnosed or treated by a physician or other health professional

YES	NO	PROBLEM	Last Date Diagnosed	YES	NO	PROBLEM	Last Date Diagnosed
		Alcoholism				Heart valve problem	
		Allergies				Enlargement heart	
		Anemia- sickle cell				Heart rhythm problem	
		Anemia – other				Other heart problem (list)	
		Arthritis, degenerative				a.	
		Osteoporosis / Osteopenia				b.	
		Asthma				Hepatitis	
		Bronchitis – chronic				Herpes (fever blisters, shingles, genital)	
		Cancer – breast				High blood pressure	
		Cancer – cervix				High blood pressure – uncontrolled	
		Cancer – colon				Hypoglycemia – low blood sugar	
		Cancer – lung				Infectious mononucleosis	
		Cancer – uterus				Migraine Headaches	
		Cancer – prostate				Obesity – more than 20 lbs or _____	
		Cancer – other				Overweight	
		Cirrhosis, liver				Peptic ulcer – gastric, duodenal	
		Colitis, spastic or ulcerative				Phlebitis	
		Congenital defect				Pneumonia	
		Diabetes (since childhood or adult onset)				Polyps in colon	
		Diabetes – uncontrolled				Regional ileitis	
		Emphysema				Rheumatic fever	
		Hay fever				Rheumatoid arthritis	
		Hearing loss left ear				Sinus trouble, chronic	
		Hearing loss right ear				Serious injury with permanent damage	
		High-blood fat (check one)				Stroke	
		_____ cholesterol				Syphilis	
		_____ triglycerides				Thyroid overactive	
		Heart attack				Thyroid under active	
		Coronary heart disease				Tension headaches	
		Rheumatic heart disease				Tension neck	
		Heart murmur				Tuberculosis	

DISABILITY

A Disability is medical problem that causes long-term impairment of your ability to work or function

Do you have medical disability?
YES ___ NO ___

If YES specify

Specify needs, functional status for disability

___ wheel chair
___ require special housing
___ use crutches
___ sports activity restricted

If you have loss or seriously limited function of any of the organs below:

___ eyes ___ ears
___ bowels ___ kidneys
___ arms or legs ___ other

ALLERGIES

An allergy is a skin rash, hives, joint pain or swelling, or fever after exposure to a desensitizing agent

Do you have any allergies? YES ___ NO ___

Have you undergone allergy tests? YES ___ NO ___ If YES, when?

Check items to which you are allergic to and indicate reaction.

Allergy	Reaction	Allergy	Reaction
___ aspirin	_____	___ penicillin	_____
___ bee stings	_____	___ poison ivy	_____
___ certain animals	_____	___ pollens, ragweed	_____
___ food allergies	_____	___ tetanus toxoid	_____
a. _____	_____	___ x-ray media	_____
b. _____	_____	___ drug allergies	_____
c. _____	_____	a. _____	_____
d. _____	_____	b. _____	_____
e. _____	_____	c. _____	_____
f. _____	_____	d. _____	_____
___ dust	_____	e. _____	_____
___ eggs	_____	f. _____	_____
___ grasses	_____		
___ mold, fungi	_____		

MEDICATIONS

Do you take any medicine frequently? YES ___ NO ___

Please indicate name, dosage and frequency

___ antacid _____	___ laxative _____
___ antibiotic _____	___ muscle relaxant _____
___ antihistamine _____	___ nasal spray _____
___ allergy shots _____	___ nitroglycerin _____
___ arthritis medicine _____	___ nerve medicine _____
___ aspirin _____	___ pain medicine _____
___ asthma medicine _____	___ penicillin _____
___ barbiturates _____	___ potassium supplement _____
___ blood thinned _____	___ rheumatic heart med _____
___ blood vessel dilator _____	___ sleeping pills _____
___ birth control pill _____	___ stomach medicine _____
___ coronary heart medicine _____	___ sulfa _____
___ cortisone steroid _____	___ tetracycline _____
___ cough medicine _____	___ thyroid hormone _____
___ cholesterol lowering _____	___ tranquilizer _____
___ diabetic pill _____	___ vitamin supplements _____
___ digitalis _____	
___ diuretic _____	1. _____
___ epilepsy _____	2. _____
___ estrogen – hormone _____	3. _____
___ headache medicine _____	4. _____
___ heart rhythm med _____	5. _____
___ high blood pressure med _____	6. _____
___ insulin _____	7. _____
	8. _____
	9. _____
	10. _____
	11. _____
	12. _____

CARDIOVASCULAR	Chest pain	Murmur	Dyspnea	Orthopnea	Rheumatic Fever	Hypertension		
	Palpitations	Edema	PND	Heart Problems	Claudication	Abnormal Tests	Other: _____	
RESPIRATORY	Cough	Sputum	Dyspnea	Bronchitis	Emphysema	TB	Bloody Cough	Wheezing
	Asthma	Pneumonia	Pleurisy	Other: _____				
GASTROINTESTINAL	Constipation	Nausea	Black Stool	Swallowing Problem	Belching/Bloating			
	Indigestion	Heartburn	Vomiting	Diarrhea	Flatulence	BM habit change	Hemorrhoids	Appetite Loss
	Pale Stool	Rectal Bleeding	Abdominal Pain	Vomiting Blood	Hepatitis	Other: _____		
INTEGUMENTARY (skin)	Rashes	Sores	Dryness	Hair Loss	Lumps	Itching	Color Change	
	Nail Change Other: _____							
BREAST	Lumps	Discharge	Discomfort	Self Exams	Other: _____			
NEUROLOGICAL	Migraines	Headaches	Weakness	Numbness	Tingling	Temors	Fainting	
	Seizures	Vertigo	Other: _____					
PSYCHIATRIC	Anxiety	Depressed Mood	Tension	Nervousness	Memory Loss	Libido Less		
	BiPolar	Schizophrenia	Other: _____					
GENITOURINARY	Urgency	Dysuria	Incontinence	Sores	Dysmenorrhea	Post Menopause	Nocturia	
	Frequency	Hesitancy	Caliber Dec	Dysparunia	Amenorrhea	OCP Use	Hematuria	
	Kidney Stones	Vaginal Bleeding	Venereal Disease	Other: _____				
HEME/LYMPH	Anemia	Bruising	Coagulopathy	Leukemia	Transfusions	Enlarge Nodes		
	HIV+	Other: _____						
MUSCLE-SKELETAL	Joint Pain	Stiffness	Arthritis	Backache	Limited ROM	Joint Swelling	Gout	
	Other: _____							
ENDOCRINE	Heat Intolerance	Cold Intolerance	Thyroid Problem	Hot Flashes	Thirst	Polyuria		
	Polyuria	Polyphagia	Diabetes	Sweating	Other: _____			
OTHERS	Other #1 _____							
	Other #2 _____							

WOMEN		
YES	NO	Have you ever
		Had a period? _____
		Date of last Period: _____
		Been on birth control pills? _____
		Had irregular periods? _____
		Been pregnant? _____

If YES:

Number of pregnancies: _____

Number of live births: _____

Weights of live births: _____

Number of miscarriages: _____

Complications? _____

MEN		
YES	NO	In the past year have you had
		Enlarge or infected prostate? _____
		Pus or drainage from penis? _____
		Rupture or swelling in groin? _____
		Nodule in testicle growing larger? _____
		Problem in sexual function? _____
		Pain or tenderness in groin? _____

WOMEN (cont...)		
YES	NO	Have you ever _____
		Had excessive pain, bleeding with periods?
		Had hard lumps or cyst in breast?
		Do you have routine annual breast exams?
		Bleeding or spotting between periods?
		Vaginal bleeding after menopause?
		Persistent vaginal itching or dryness?
		Treatment for vaginal infection or discharge?
		Problem with sexual dysfunction?
Date of last pelvic exam and PAP		
Age at time of menopause		

CHILDREN ONLY		
<p>The following questions pertain specifically to children. This information will help us to ascertain an overall picture of the child's medical problems.</p>		
YES	NO	
		Chronic runny nose?
		Chronic red, itchy eyes?
		Purulent drainage from eyes or ears?
		Chronic sneezing spells?
		Purulent episodes of areas of patchy scaly skin?
		Whining episodes?
		Sudden changes in temperament?
		Spells of intense temper with fury?
		Few friends?
		Problem being shy/timid?
		Crying spells without reason?
		Difficulty learning simple task?
		Writing problems?
		Reading problems?
		Speaking problems or stuttering?
		Problems in school?
		Disciplinary problems?
		Problems gaining weight?
		Finicky/picky eating habits?
		Periods of fatigue/lethargy?
		Night sweats?
		Problems with bed wetting?
		Problems with frequent diarrhea or constipation?
		Problems with bowel or urine incontinence?
		Episodes of hyperactivity?
		Sleeping problems/nightmares?
		Problems with sluggishness in the morning?