

Personal Medical history: page 1

Today's date: _____

Patient name: _____

DOB: _____ Age: _____ Gender: _____

Past medical history: Please check all conditions you have ever been diagnosed with. Explain details below the check off list, please. Include whether problem is past or current and approximate date of onset.

Hypertension ___ Diabetes ___ Heart disease ___ Heart attack ___ Liver disease ___ Kidney disease ___
Lung disease ___ Asthma/COPD ___ Cardiovascular disease ___ Cerebrovascular disease ___ Stroke ___
TIA ___ Cancer ___ GERD ___ Hepatitis ___ Osteoporosis ___ Arthritis ___ Seizure disorder ___
Thyroid disorder ___ Bleeding disorder ___ Infectious disease ___ Breast disease ___ Anemia ___
Transfusions ___ Anxiety ___ Depression ___ Other psychiatric ___

Past Surgical history: Check all that apply. Include procedures not on the check off list below. Explain details. Give approximate surgery dates and any complications.

Tonsillectomy ___ Appendectomy ___ Gallbladder ___ Hernia ___ Hysterectomy ___ C-section ___
Back surgery ___ Knee surgery ___ Hip surgery ___ Other orthopedic surgery ___

Hospitalizations: approximate dates, reason

Current prescription medications: list names, strength, dosage interval reason for taking and duration of use:

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Current over the counter medications: list names, strength, dosage interval reason for taking and duration of use:

Current vitamins, minerals, herbs, remedies or other supplements currently being taken : list names, strength, dosage interval reason for taking and duration of use:

Allergies: Check all that apply.

No known drug allergies

Medication

Environmental

Foods

Latex

Intravenous contrast dye

Other

Details of above allergies:

Reproductive history

Females:

Age at onset of menses _____ Still menstruating First day of last menses (date) _____

Interval between cycles (indicate days or weeks) _____ Duration of flow _____

Quality of flow heavy medium lite very lite

Check all that apply: cycles regular irregular severe cramping bleeding between cycles

PMS

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Reproductive history (continued)

Number of pregnancies _____ Number of live births _____ Number of miscarriages _____ Number of abortions _____

Birthing complications: _____

Menopause: Age at onset _____ Abnormal vaginal bleeding since? Yes/No

Symptoms: _____

Hormones/herbs/supplements: _____

Males and Females answer the following:

I prefer not disclosing sexual related information ____

Sexually active Yes/No

Contraception method: _____

Check all that apply: same sex partner ____ opposite sex ____ abstinent ____ single partner ____

multiple partners ____ greater than 4 lifetime partners ____

Sexually transmitted infection history: None/or as noted:

Any sexually related concerns Yes/No

PATIENT INTAKE INFORMATION

PLEASE PRINT LEGIBLY

Patient's First name: _____ Last name: _____ MI: _____

Street address: _____ email: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

DOB: _____ Social security number: _____ Marital status _____

Age: _____ Height: _____ Weight: _____ Gender: _____ Patient is an adult _____ minor _____

If patient is a minor, parent or legal guardian please fill out the following:

Parent(s) or legal guardian(s) name: _____

Relation to patient: _____

Street address: _____ email: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Please indicate full name, phone number(s) and relationship of your emergency contact below:

If someone other than the patient is responsible for payment, please complete the following:

Full name of responsible party: _____ relationship _____

Street address: _____ email: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Method of payment: cash ___ check ___ credit card ___

I, the undersigned, understand that the medical office of Louis Esquivel, MD,PA does not file insurance claims, nor does it accept insurance assignments. Payment is expected in full at the time of the visit unless arrangements have been made prior to the appointment, and that payment may be made in the form of cash, check or major credit card. I hereby authorize and request that I/my child/minor I am legally responsible for be treated by Dr. Louis H Esquivel. This authorization remains in effect until it is revoked in writing. The information I have provided is true and accurate to the best of my knowledge. If the information should change during the course of my/my child's/minor I am legally responsible for treatment, I will notify the office manager for Louis Esquivel, MD, PA in writing of the changes.

Date: _____ Printed name: _____ Signature: _____