EL DORADO HILLS SPORTS MEDICINE

(office use) Medical Record # ________________

NEW PATIENT INFORMATION FORM

Patient name (first, middle, last): ____

Date of birth: __________ **Gender:** __Male __Female **Social security:** _____-____-_____

Email address:____

Race: __American Indian; __Asian; __Black/African-American; __Native Hawaiian/Pacific Islander; __White

Ethnicity: ___Hispanic ___Non-Hispanic ___Decline to state

Home address: ______________________________________

City: _______________________ State: ______ Zip: ________

Phone #: Home (_____)_________ Mobile (_____)_________ Work (_____)_________

Preferred method of contact: ___ Email ___ Phone call ___Text message (Circle # above)

Marital status: _____Married _____Single _____Divorced _____Separated

_____Domestic partner _____Widowed

Occupation: _________________________________Employer:___________________

Primary Care Physician: ______________________ PCP phone #: (_____)__________

Who referred you to us? ____

EMERGENCY CONTACT

Name: _______________________________ Relationship to patient: ______________

Phone: _____________________ Email: _____________________________________

MEDICAL INSURANCE

(WE WILL NOT BILL THIS INSURANCE COMPANY, HOWEVER THIS INFORMATION IS REQUIRED FOR YOUR ACCOUNT WITH US. PLEASE REFER TO OUR FINANCIAL POLICY.)

Insurance company: ______________________________

I.D. #: ____________________________ Group #: _________________________

Subscriber's name: _______________________ Subscriber's Date of Birth: ___________

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PATIENT OR AUTHORIZED PERSON SIGNATURE

Please read and initial each statement:

_____ I authorize all medical treatments deemed necessary by El Dorado Hills Sports Medicine (EDHSM).

_____ I have received and read the EDHSM HIPAA Notice of Privacy Practices.

_____ I have received and read the EDHSM Financial Policy Notice.

_____ I give permission for staff to leave a message when calling to confirm appointments.

_____ I understand that payment is due at time of service and that I am financially responsible for all charges.

SIGNATURE ____ DATE: _______________

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Consent for Photography

(FOR PATIENT IDENTIFICATION PURPOSES ONLY)

Patient name: ____

I hereby give my consent to have a facial photograph taken of myself or a family member to be used for patient chart identification purposes only.

____ Patient signature

___________________________ Date

____ Parent/Guardian signature (if patient is under 18)

___________________________ Relationship to patient

El Dorado Hills Sports Medicine
903 Embarcadero Drive, Suite 2
El Dorado Hills, CA 95762
Phone: 916-293-8035
Fax: 916-805-5507

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ___________________________________

I have received a copy of this office's Notice of Privacy Practices.

_______________________________________ _____________________

Patient signature Date

_______________________________________ _____________________

Parent/Guardian signature (if patient is under 18) Relationship to patient

El Dorado Hills Sports Medicine
903 Embarcadero Drive, Suite 2
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NEW PATIENT HEALTH HISTORY FORM

(THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. THIS INFORMATION WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR PRIOR CONSENT.)

Patient name: ____ Date of birth: _____________

Today's date: ___________________

MEDICATIONS: Please list all prescription and non-prescription medications, including vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc.).

Medication	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES or intolerance to medications? (circle one) Yes No known allergies

If yes, to what medication & what is the reaction/intolerance?

____

PERSONAL MEDICAL HISTORY:
Do you have (or have had in the past) any of the following conditions?

Condition	Now	Past	Comments
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			

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Condition	Now	Past	Comments
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast lump (benign)			
Cancer, Breast			
Cancer, Colon			
Cancer, Ovarian			
Cancer, Prostate			
Cancer, Other Type			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			
Gallbladder disease			
Gastroesophageal Reflux (Heartburn/ GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			

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Condition	Now	Past	Comments
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Other (list)			

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SURGICAL & PROCEDURE HISTORY: Please list any abnormal findings, details or complications under comments.

Surgical Procedure	Yes	Year	Comments
Abdominal surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back surgery (lumbar)			
Biopsy (location in comments)			
Breast Biopsy			Circle one: Right Left Both
Breast surgery			Circle one: Right Left Both
Colonoscopy			
Coronary Bypass			
Coronary Stent			
C-Section			
Echocardiogram (heart)			
EGD (Stomach Endoscopy)			
Gallbladder Removal			Laparoscopic?
Heart Surgery (other than coronary bypass)			
Hip Surgery			Circle one: Right Left Both
Hysterectomy (partial, ovaries left)			Circle one: Laparoscopic/Vaginal/ Abdominal
Hysterectomy (total, including ovaries)			Circle one: Laparoscopic/Vaginal/ Abdominal
Knee Surgery			Circle one: Right Left Both
LEEP (Cervix surgery)			
Neck (spine) surgery			
Ovary Removal			Circle one: Right Left Both
Pulmonary Function Test			
Sigmoidoscopy			
Sinus Surgery			

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Surgical Procedure	Yes	Year	Comments
Stress Test (stress echo)			
Stress Test (thallium/perfusion)			
Stress Test (treadmill)			
Tonsillectomy			
Tubal Ligation			
Vasectomy			
Other (list)			

FAMILY HISTORY: (If you are adopted and you do not know your family history, skip the Family History section and continue to the next section.)

	Mom (M)	Dad (D)	Sister (S)	Brother (B)	Mom's Mom (MGM)	Mom's Dad (MGF)	Dad's Mom (PGM)	Dad's Dad (PGF)	Comments
Alive									
Deceased									
Age currently or at death									

Indicate which relative(s) has had the following diseases:

Diseases & Conditions	M	D	S	B	MGM	MGF	PGM	PGF	Other blood rela-tive	List age(s) at diagnosis if known; was this the cause of death?
No significant history known										
Hypertension – high blood pressure										
Hyperlipidemia – high cholesterol										

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Diseases & Conditions	M	D	S	B	MGM	MGF	PGM	PGF	Other blood rela-tive	List age(s) at diagnosis if known; was this the cause of death?
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes Type 2 (adult onset)										
Cancer, Breast										
Cancer, Colon										
Cancer, Prostate										
Osteoporosis										
Depression										
Alcoholism / Drug Abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Lung										
Cancer, Ovarian										
Cancer, Other type										
Colon Polyp										
Diabetes Type 1 (childhood onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										

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Diseases & Conditions	M	D	S	B	MGM	MGF	PGM	PGF	Other blood rela-tive	List age(s) at diagnosis if known; was this the cause of death?
Heart Disease (Other)										
Hepatitis B or C										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Stroke										
Sudden Cardiac Death										
Other (list)										
Other (list)										

SOCIAL HISTORY

Tobacco Use:

______ Never smoked.

______ Current smoker. _________ packs/day. _________ # of years.

Are you ready to quit? (circle one) No Yes

______ Former smoker. Quit date: _________

Approximately how many packs/day did you smoke? _________

How many years did you smoke? _________

Other tobacco use? Snuff Chew Currently use? _________ If No, quit date: _______

Alcohol Use:

Do you drink alcohol? No Yes

Average # of drinks per week: _________________________

What do you drink? (circle all that apply) Beer Wine Liquor Other

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Drug Use:

Have you ever used recreational drugs? (circle one) No Yes

If yes, which ones? ____

Quit which ones? ____

Any used currently? ____

Exercise:

How many days per week do you engage in moderate physical activity (sustained elevated heart rate for 30 to 60 minutes)?

_____ Not at all

_____ Occasionally (1-2 days)

_____ Often (3-4 days)

_____ Regularly (5-6 days)

_____ Daily

What kind of physical activity? ____

____

Safety:

Does your home have a working smoke detector? (circle one)	Yes	No
Do you have guns in your home? (circle one)	Yes	No
If yes, are they locked up and ammunition stored separately?	Yes	No

(CONTINUED NEXT PAGE)

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REVIEW OF SYSTEMS

Do you **currently** have any of the following symptoms? (Circle all that apply)

General Fever Fatigue Night sweats Weight changes (unexpected)	**Eyes** Itchy Blurry vision Discharge Pain Redness Glasses/contacts	**Ears, Nose, Throat/Mouth** Ear pain Ear Drainage Hearing loss Ear ringing Oral lesions Tongue swelling
Cardiovascular High blood pressure Low blood pressure Chest pain Palpitations Abnormal rhythm Swelling in arms or legs Fainting Murmur Valvular disease	**Respiratory** Difficulty breathing Wheezing Asthma Cough Shortness of breath with exertion	**Gastrointestinal** Abdominal pain Constipation Diarrhea Heartburn/Acid reflux Bloody or dark stool Nausea Vomiting
Heme/Lymph Anemia Bleeding Easy bruising Blood clots Irregular periods Heavy periods Missed periods	**Genito-urinary** Blood in urine Sexually transmitted disease (hx) Urinary incontinence Kidney stones Frequent urination Urgency with urination Pain with urination	**Skin/Breast** Abrasion Dermatitis Rash Breast lump
Musculoskeletal Neck pain Back pain Shoulder pain Elbow, wrist or hand pain Hip pain Knee pain Ankle or foot pain Joint stiffness Joint swelling Tender joint Muscle pain Weakness	**Neurological** Numbness Tingling Loss of strength Loss of balance Seizures Head injury Nerve damage Difficulty concentrating	**Behavioral** Anxiety Sadness Panic attacks

End of Health History form.