Patient History Form for patient _____

Date _____ Date of Birth _____

Please feel free to print and then fill out these forms and bring them to your first visit with the doctor. This will help us serve you better.

Current Medications and doses;

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

Do you have any chronic medical conditions, if the answer is "yes" please list

1._____ 2._____

3._____ 4._____

Please list any prior surgeries or hospitalizations.

1._____

2._____

3._____

4._____

5._____

Do you have any allergies to medications or other things? If yes, please list them.

Personal habits:

Do you exercise for at least 30 minutes least 3 times a week?_____

How many cups of coffee or tea do you consume a day? _____

Do you smoke tobacco? _____ IF yes, how much do you smoke per day _____.

Are you a former smoker?_____ If yes, when did you quit?_____

How many alcoholic drinks do you usually have in one day?_____(1 mixed drink = 1 beer =1 glass of wine. Have you ever had a chemical dependency problem?_____

Social History: Marital Status: married ____ single ____ divorced ____ widowed _____

Sexual Preferences; heterosexual ____ homosexual _____ bisexual _____

Current Occupation _____ Hobbies _____

Children? _____ Religious preference _____

Family History; Have any of your immediate family been diagnosed with any of the following diseases? If the answer is yes, please circle the disease and state which family member was affected.

Asthma _____

Chronic Allergies _____

Breast Cancer _____

Colon Cancer _____

Ovarian Cancer _____

Prostate Cancer _____

Melanoma _____

Other cancer _____

Heart Attack _____

High Blood Pressure _____

Stroke _____

FAMILY HISTORY CONTINUED

Adult Onset Diabetes _____

Insulin Dependent Diabetes _____

High Cholesterol _____

Blot Clots in legs or Bleeding Disorders?_____

Rheumatoid Arthritis _____

Systemic Lupus _____

Scleroderma, Reiter's Syndrome or Sjogrens Syndrome_____

Depression _____

Tuberculosis _____

Hemophilia or other bleeding disorder _____

Parkinson's _____

Alzheimer's _____

Any other inherited diseases

Is your mother alive?____ If not , what was her cause of death?_____

How old was she now or if deceased, how old was she at the time of her death ?_____

Is your father alive? _____ If not, what was his cause of death?_____

How old is he now, or if deceased, how old was he at the time of his death? _____

Do you have siblings?_____

Review of Systems: Please answer "yes" or "no" to each of the following;

General: Are you currently experiencing chronic fevers or shaking chills? ___ any chronic night sweats? _____. Has your weight changed by more than 10 lb. , in the past 12 months? _____. Was this change in weight intentional ? _____. Have you recently had a loss of appetite? _____.

HEENT: Do you have a history of hayfever or seasonal allergies? _____. Do you have chronic nasal congestion? _____ or chronic sore throat? _____. Do you have a loss of hearing? ____ or sense of smell? _____. Do you were contacts or glasses? _____. Any recent sudden change in vision? _____

Lungs: Do you have a history of asthma? _____ , chronic bronchitis? _____ , or emphysema? _____

Do you have a history of a positive skin test for TB? _____ or a history of active TB_____.

Do you currently have a chronic cough? ____. Have you recently coughed up blood? _____

Cardiovascular: Do you have a history of rheumatic fever? _____ Any history of a heart murmur? _____ . Do you have a history of angina attacks?_____ or heart attack? _____. Do you get more short of breath than your peers when exercising? _____. Do you wake up at night short of breath? _____. Can you climb a flight of stairs without stopping to rest? _____. Do you have a history of fainting? ____. Any recent palpitations? _____. Have you been treated for heart disease? _____ or hypertension (high blood pressure) ? _____. Do you often get cramps in your legs when walking? _____

Gastro-intestinal: Do you have a history of stomach ulcers? _____. Do you have chronic indigestion? ____ or heart burn several times a week? ____. Do you have trouble swallowing your food ? _____. Any chronic nausea or vomiting? _____Are you currently suffering from chronic diarrhea, (4 or more stools per day for > 2 weeks) ?_____. Any recent change in the pattern of your bowel movements. Any blood in your stool? _____Any black or tarry looking stool? ____. Do you have a history of hemorrhoids? _____. Any chronic abdominal or pelvic pain? _____

Urinary: Do you currently have pain when you urinate? ____ or blood in your urine? _____.

Have you had kidney stones? ____. Any history of kidney infections? _____. Do you have to get up at night to urinate? _____. If yes, how many times? _____

MEN: any history of prostate problems? _____. Any history of erectile dysfunction or impotence? _____. Do you have testicular pain or any lumps in your testicles? _____

WOMEN: Any problems with incontinence when you cough, laugh, sneeze or lift heavy

loads? _____. Have you recently had 3 or more bladder infections per year? _____.

Genital: Any history of venereal diseases like; Herpes Simplex? _____ , Chlamydia ? ____,

Gonorrhea ?_____ or HIV? _____. Any sores on your genitals? _____

Gyn: Age you started your periods/ ____. Do you currently have any unusual vaginal discharge?____

FOR WOMEN YOU CURRENT HAVE MENSTRUAL CYCLES : If you have periods, are they regular? _____. How many days do they last? _____. Has the frequency or heaviness of your periods recently changed? _____. Any spotting or bleeding between periods? _____ Do you have significant PMS? _____. Are you taking birth control pills? ____ . Other birth control? ___

POST MENOPAUSAL WOMEN ONLY. If you are no longer having periods at what age did they stop? ____. If you are postmenopausal, have you had any spotting or bleeding recently? ____. Are you taking

hormone replacement therapy (estrogens)?_____.

Endocrine: Are consistently colder that other people?____ or hotter? _____. Any recent changes in the texture of your skin or hair? _____. Do you urinate more than normal? _____. Are you chronically very thirsty? _____. Have you ever been treated for diabetes or thyroid problems? _____ .

Neurological: Have you ever had a seizure? ____. Have you had a stroke? _____. Any problems currently with tingling or numbness in your limbs? _____. Have you ever had any temporary problems with slurred speech or weakness in your limbs? _____. Do you suffer from migraines? ____, or other forms of chronic headache? ____.

Skin: Do you have any current rashes? ____. Any history of skin cancer? _____. Do you have any moles that have recently; grown rapidly? ____, changed color?_____ , changed shape? _____, started itching? ____, or started bleeding? _____.

Orthopedics: Have you had any orthopedic surgery? _____. Any broken bones? ____. Do you have any chronically painful joints? ____. If so which
_____

Do you have chronic back pain? _____.

James B. Cordell, MD NEW PATIENT REGISTRATION FORM

Today' date _____ Patient's Date of Birth _____

Name (last, first, middle_____

Phone #s **Home (_____)_____**

Daytime (_____)_____

Responsible Party (if a minor)_____

Street Address _____

City _____ State _____ Zip _____

Sex ___ Male ___ Female. Age _____ Single ____ Married ____ Divorced ____ Widowed _____

Patient employed by _____

Business Address _____

Occupation _____ Social Security # _____-_____-_____

Spouse's Name _____ Birth date _____ SS#_____

Employed by _____ Work phone _____

Who is responsible for this account? _____

Relation to patient? _____

Medical Insurance? Yes ____ No ___. Medicare? ____ Tricare ____

Name of Primary Insurer _____

Member #_____ Group # _____ Subscriber #_____

In case of Emergency , who should be notified? Name _____

Phone _____

Assignment and Release:

I, the undersigned , have medical insurance with _____

(name of insurance company)

and assign to Dr. James Cordell all medical benefits , if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, even if my insurance company does not pay my bill. . I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions.

I also understand that it is the policy of Dr. Cordell to charge for missed appointments and physicals, if they are not cancelled more than one full business day prior to the time of the appointment. I agree to pay these charges for missed appointments and understand that neither Medicare nor commercial insurance will cover costs for missed appointments.

_____ Date _____

Medicare Authorization:

I request that payment of authorized Medicare Benefits be made on my behalf to

Dr. James Cordell for any services he renders to me. I authorize the holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance " is indicated on item 9 of the HCFA 1500 form or on electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co insurance and deductible are based upon the charge determination of the Medicare carrier.

I also understand that Medicare will not cover the cost of many preventative services including annual physicals and labs and EKGs associated with annual physicals. (the exception is the new benefit starting in 2006, for a single initial physical within 6 months of becoming eligible for Medicare)

Signed_____ Date _____ , 200__