LIVE WELL MEDICAL CENTERS ORLANDO
7051 Dr. Phillips Blvd. Suite 3 • Orlando, FL 32819

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

Sex: ☐M ☐F Age ____ Birthdate _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

CONTACT INFORMATION

Cell _____ Home _____ Work _____ Ext _____

Email _____

Preferred method of contact _____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone _____ Work Phone _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____for any services furnished me by that physician. I authorize any holder of medical information about me to release to the 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 requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

ALIVE DECEASED	FATHER ☐ ☐	Present health or cause of death	MOTHER ☐ ☐	Present health or cause of death	SPOUSE ☐ ☐	Present health or cause of death

BROTHERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** ☐Diabetes ☐Cancer ☐Bleeding tendency ☐Kidney disease ☐Tuberculosis

☐Heart disease ☐Stroke ☐High blood pressure ☐Nervous illness ☐Allergy ☐Other _____

- OVER -

MEDICAL HISTORY All information is strictly confidential.

Check (√) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes/Halos

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____
Date of last Pap Smear_____
Have you had a mammogram? ____
Are you pregnant? _____
Number of children _____

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heartbeat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change of moles
- ☐ Scars
- ☐ Sore that won't heal

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Check (√) conditions you have or have had in the past.
- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations_____

MEDICATIONS / ALLERGIES

List medications you are currently taking _____
_____

Pharmacy Name _____ Phone _____

List allergies to medications or substances _____
_____
_____

HEALTH HABITS

HEALTH HABITS Check (√) which Substances you use and describe How much you use.
- ☐ Caffeine _____
- ☐ Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

OCCUPATIONAL Check (√) if your work exposes you to the following:
- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____

NEW PATIENT QUESTIONNAIRE

Name: _____
Address: _____
Date of Birth: _____
Phone: _____

CHIEF COMPLAINT

1. Please mark symptoms that you have had in the last 6 months and/or currently experiencing: (Please include: onset, severity, duration, possible causes, and remedies tried.)

☐ Decreased Energy_____

☐ Fatigue_____

☐ Weight Gain/Loss_____

☐ Insomnia/Snoring_____

☐ Decreased Libido_____

☐ Hair Loss/Skin Changes_____

☐ Muscle Weakness_____

☐ Joint Pain/Back Pain_____

☐ Hot Flashes_____

☐ Night Sweats_____

☐ PMS/PMDD/Irregular Menses_____

☐ Other_____

MEDICAL HISTORY

2. Please choose any medical conditions that you are currently being treated for or have been treated for in the past five years, and include dates. (Initial here if none ___)

☐ Hormone Replacement_____ (If yes, ☐ Bio-Identical or ☐ Synthetic?) ☐ Hypothyroidism_____

☐ Hyper/Hypotension_____ ☐ Cardiovascular Diseases (Please be specific)_____

☐ Asthma_____ ☐ Arthritis_____ ☐ Diabetes_____ ☐ High Cholesterol_____

☐ Anxiety_____ ☐ Depression _____ ☐ Myalgias_____ ☐ Shiftworker Disorder_____

☐ Sleep Apnea_____ (If yes, are you compliant w/ CPAP? ☐ Yes ☐ No) ☐ Insomnia_____

☐ Cancer_____(If yes, what type and what is your current status?) _____

☐ Other_____

3. Are you being treated for any infectious diseases? If so please include details.
(Initial here if none ___)

_____

SURGICAL HISTORY

4. Please list below any past surgeries and dates. (Initial here if none ___)

_____
_____
_____
_____
_____

FAMILY HISTORY

5. Please list below any family member's health problems - primarily mother/father and life status. (Initial here if none ___)

_____
_____
_____
_____
_____

SOCIAL HISTORY

6. Do you use or have you used tobacco products? If so, what type, how much, and for how long? (Initial here if none ___)

Cigarettes_____ Cigars_____ Smokeless_____

7. Do you drink alcoholic beverages? ☐Yes ☐No If so, how often? (Initial here if none ___)

_____

ALLERGIES

8. Have you had any allergic reactions to the following:

Medications? ☐Yes ☐No If so, what type of reaction? (Initial here if none ___)

_____
_____
_____

Any type of food? ☐Yes ☐No If so, what type of reaction? (Initial here if none ___)

_____
_____
_____

Any of the following? (Initial here if none ___)

Pollen ☐Yes ☐No **Dust** ☐Yes ☐No **Pet Dander** ☐Yes ☐No **Mold** ☐Yes ☐No

Rag Weed ☐Yes ☐No **Latex** ☐Yes ☐No **Surgical Tape** ☐Yes ☐No

Bee/Wasp Stings ☐Yes ☐No **Other**_____

MEDICATIONS

11. Please list below any medications and/or vitamin supplements you are currently being prescribed. Please be sure to include strength and dosages. (Initial here if none ___)

_____

_____

_____

_____

_____

12. What prior medications and/or treatments have you tried in the past?
(Initial here if none __)

_____

_____

_____

_____

_____

FEMALES ONLY

13. How many pregnancies have you had? ___ What type of deliveries?
(Initial here if none ___)

_____

14. Have you had a ☐partial or ☐total hysterectomy? (Initial here if none ___)
If total, were both ovaries removed? ☐Yes ☐No

15. Please list dates of the following: (Please Specify--Normal or Abnormal)

Last Menstrual Cycle _____ ☐Normal or ☐Abnormal

Last Papsmear_____ ☐Normal or ☐Abnormal

Last Mammogram_____ ☐Normal or ☐Abnormal

Female patients over 40 years of age—Have you had any of the following?

18. Colonoscopy ☐Yes ☐No When? _____ ☐Normal or ☐Abnormal

19. Bone Density ☐Yes ☐No When? _____

MALES ONLY

16. Have you had a vasectomy? ☐Yes ☐No When? _____

17. Please list date of last prostate exam: _____

Male patients over 40 years of age—Have you had any of the following?

18. Colonoscopy ☐Yes ☐No When? _____ ☐Normal or ☐Abnormal

19. Bone Density ☐Yes ☐No When? _____

Any other concerns or questions—please list below:

_____
_____
_____
_____
_____