Confidential Individual Health Record

Today's Date:____/_____/_____

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Miss Prof. other: _____
Last:_____ First:_____ Middle: _____
Suffix: Jr Sr II III MD PhD DO Esq PA RN BSN other:_____ Birth Date: ____/____/_____ Age:_____ Sex: Male / Female
Primary Language: English French German Spanish other: _____
Marital Status: Single Married Widowed Divorced Separated

Address:
_____
_____Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____
Cell Phone: (_____) _____-_____ ext _____ Fax #: (_____) _____-_____ ext _____
Email Address:
_____

Emergency Contact

Title: Miss Mrs. Ms. Master Mr. Dr. Prof. Rev. other: _____
Last:_____ First:_____ Middle: _____
Suffix: Jr Sr II III MD PhD DO Esq PA RN BSN other:_____
Address: _____Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Relationship: Spouse Relative Friend Other _____
Email Address: _____

How did you hear about us?

Family _____ Friend _____ Co-Worker _____ Close to home/work Dr. _____ Internet search _____

Employment Information

Occupation/Job Title: _____

Job Description _____

Current Health Condition

Unwanted Condition (Why you are contactingus?):_____
When did this Condition BEGIN? _____/_____/_____

Do you SUFFER with ANY OTHER Condition than which you which you would like to tell us?

_____
_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of managing your medications. However, these questions must be answered carefully as the problems can affect your overall course of care.

(Circle or check what pertains to your issues.)

Constitutional: **I DO NOT have nor having had any of the symptoms or problems listed below.**
chills fatigue night sweats weight loss daytime drowsiness fever weight gain

Eyes/Vision: **I DO NOT have nor having had any of the symptoms or problems listed below.**
blindness blurred vision cataracts change in vision double vision eye pain
field cuts glaucoma itching photophobia tearing wear glasses/contacts

Ears, Nose and Throat: **I DO NOT have nor having had any of the symptoms or problems listed below.**
bleeding dentures difficulty swallowing discharge dizziness

Respiration: **I DO NOT have nor having had any of the symptoms or problems listed below.**
asthma cough coughing up blood sputum production shortness of breath wheezing
ear drainage ear pain fainting frequent sore throats headaches hearing loss
history of head injury hoarseness loss of sense of smell nasal congestion nosebleeds
postnasal drip rhinorrhea (runny nose) sinus infections snoring sore throat
innitus (ringing in ears) TMJ problems

I DO NOT have nor having had any of the symptoms or problems listed below.
Cardiovascular:
angina (chest pain or discomfort) chest pain claudication (leg pain/ache)
heart murmur heart problems

Gastrointestinal:
abdominal pain belching black - tarry stools constipation
shortness of breath with exertion or exercise swelling of legs ulcers
varicose veins high blood pressure low blood pressure
orthopnea (difficulty breathing lying down) palpitations
paroxysmal nocturnal dyspnea waking at night w/ shortness of breath)

I AM NOT experiencing any of the symptoms or problems listed below.
diarrhea difficulty swallowing heartburn hemorrhoids indigestion jaundice
nausea rectal bleeding abnormal stool caliber abnormal stool color
abnormal stool consistency vomiting vomiting blood

FEMALES --- I DO NOT have any of the symptoms/problems and/or using any of the items listed below.
birth control breast lumps/pain burning urination cramps
frequent urination hormone therapy irregular menstruation vaginal bleeding
pregnancy vaginal discharge urine retention

MALES: I DO NOT have any of the symptoms or problems listed below.
burning urination frequent urination prostate problems
erectile dysfunction hesitancy/ dribbling urine retention

Endocrine: **I DO NOT have any of the symptoms or problems listed below.**
cold intolerance diabetes excessive appetite excessive hunger
excessive thirst abnormal frequency of urination goiter unusual hair growth
hair loss voice changes heat intolerance

Skin: **I DO NOT have any of the symptoms or problems listed below.**
changes in nail texture changes in skin color hair growth hair loss hives
history of skin disorders itching skin lesions / ulcers paresthesias varicosities
rash

Nervous System: **I DO NOT have any of the symptoms or problems listed below.**
dizziness limb weakness facial weakness loss of consciousness headache loss of memory

Psychologic: **I DO NOT have any of the symptoms or problems listed below.**
numbness seizures
slurred speech stress tremor unsteadiness of gait/ loss of balance
sleep disturbance strokes anhedonia behavioral change convulsions memory loss
anxiety bi-polar disorder depression mood change confusion insomnia
loss or change in appetite

Allergy: **I DO NOT have any of the symptoms or problems listed below.**
anaphalaxis itching chronic nasal congestion sneezing food intolerance
acute nasal congestion rash

Hematologic: **I DO NOT have any of the symptoms or problems listed below.**
anemia blood clotting bruising easily lymph node swelling bleeding
blood transfusion fatigue

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Would you like us to work with your doctor on your overall medication management? Yes No

If yes, please complete the following:

Doctor's Name: _____ Number : _____
Date of Last Visit: _____ _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific. If you need record all the medication on another sheet, please do and fax it along with this form.**

Medication
Dosage
For What Condition?
How long have
you been taking this?

Medication
Dosage
For What Condition?
How long have
you been taking this?

Medication
Dosage
For What Condition?
How long have
you been taking this?

Current Vitamins, Herbs, etc: **List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific. If you need record all the medication on another sheet, please do and fax it along with this form.**

Dosage
For What Condition, if any?
How long have
you been taking this?

***Childhood Illness** (es):* **LIST all health conditions. CIRCLE all CURRENT conditions.**

ADD atopic dermatitis (eczema) allergies/hayfever chicken pox crohn's/colitis depression
headaches hepatitis HIV scoliosis seizure disorder sickle cell anemia anemia
asthma bedwetting cerebral palsy diabete ear infections fetal drug exposure
Food allergies (list)
_____
_____
measles spina bifida mumps other:
_____
psoriasi rash

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

***Adult Illness** (es):* **LIST all health conditions. CIRCLE all CURRENT conditions.**

ADD Alzheimer anemia arthritis asthma cancer cerebral palsy chicken pox
crohn's/colitis CRPS (RSD) CVA (stroke)
cystic kidney disease depression diabetes (insulin dep) diabetes (non insulin) eczema
emphysema eye problems fibromyalgia heart disease hepatitis HIV
hypertension influenzal pneumonia liver disease lung disease lupus erythema (discoid)
lupus erythema (systemic) multiple sclerosis parkinson's disease unspecified pleural effusion
pneumonia psoriasis psychiatric problems scoliosis seizures shingles
past history of similar symptoms STD's (unspecified) suicide attempt(s) thyroid problems
vertigo other:

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

angioplasty appendectomy caesarian section cardic catheterization carpal tunnel repair
coronary artery bypass cosmeti D&C dental sugery gall bladder hemorrhoidectomy
hernia repair hysterectomy joint reconstruction joint replacement knee repair
laminectomy mastectomy pacemaker insertion rotator cuff spinal fusion
tonsilectomy other:

Females ONLY: Ob/Gyn **Mark all that apply below.**
If you have been pregnant in the past, please fill in the appropriate information below.
Menstrual History.
Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

_____ Number of complicated pregnancies	**_____ Number of uncomplicated pregnancies**
_____Number of C-sections	**_____ Number of vaginal deliveries**
_____ Number of miscarriages	**_____ Number of terminated pregnancies**
I... am currently pregnant	**am NOT currently pregnant**

I... currently have menses.	**currently DO NOT have menses.**
My menses... are regular.	**are NOT regular.**
_____ Age of first menses	**_____ Age when metaphase began**
Date of last menses: _____/_____/_____	

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above: 1. angioedema 3. GI disturbance 5. joint pain 7. shortness of breath
2. anaphylaxis 4. headache 6. rash 8. unspecified reaction

Social History:

Mark all that apply below.

Alcohol: do not drink alcohol social consumption only drink the following regularly (mark below)
beer liquor wine; quantity of _____ oz./glasses per day week month

My Dietary Intake consists mainly of the following: (mark all that apply)
high fat
high fiber
high protein
high salt low fiber low calorie low salt
low carbohydrate low sugar

Mark the highest level of Education completed:
pre-school
elementary school middle school
vocational school
high school
high school graduate
GED
high school – incomplete
college
college graduate associates degree bachelors degree
doctorate
graduate school
graduate degree
other: _____

Substance: never used illegal drugs has not used illegal drugs since _____ .
never used IV drugs used illegal drugs for _____ (how long?)

Tobacco: Do not use tobacco Do not smoke cigars, cigarettes or pipe
Live with a smoker
Quit smoking Smoke: # ____ per Day Week Month;
Chew: #_____cans per Day Week Year

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment and immediately due and payable. I also understand that PURE recommends always that you tell all your health care providers about any alternative practices you choice to use. Do this during routine visits, examining physicians normally do not ask the patience about alternative practices being used. Give them a full picture of what you do to manage your health. This will help ensure coordinated and safe care.

I hereby authorize the PURE Meds Manager to review my history provided above, to recommend and advise me to suggestions he or she deems appropriate and a course of action to take. It is understood and agreed the amount paid the patient also agrees that he/she is responsible for all fees incurred and have been advised of those fees prior to signing this document.

Patient Print Name: _____ Patient's Signature: _____
Date: _____

Consent to treat a Minor: _____

Guardian or Spouse's Signature of Authorizing Care: _____

I acknowledge that I have received the PURE's Notice of Privacy Practices for protected health information.

Patient Print Name: _____
Patient's Signature: _____ Date: _____