Hobdari Family Health
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PATIENT INFORMATION

Thank you for choosing HOBDARI FAMILY HEALTH In order to properly serve you, we need the following information.

PATIENT INFORMATION

Name: (Last, First, MI) _____ Email: _____

Address: (Street) _____ (City, St, Zip) _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Social Sec#: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Place of Employment: _____ Occupation: _____

Employer's Address: _____

Extended Information: (Choose One) ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Parent's Name: _____ Relationship: _____

Spouse/Parent's Employer: _____ Work Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

IF SEASONAL RESIDENT: 2nd Address _____

DATES AT 2ND ADDRESS: From _____ To _____

Guarantor/Responsible Party: (Person Responsible for Payment of Your Service if different from Patient)

Name: _____ Relationship to Patient: _____

Address (if different from Patient): _____

INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____ SS# _____

Insurance Co: _____ Policy #: _____ Group #: _____

Choose One: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ No ☐ Yes If Yes, please complete the following:

Insurance Co: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other:

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services.

I give my permission to leave phone messages regarding my medical care/appointment confirmation: ☐ Yes ☐ No

☐ Check here if you prefer to be contacted by email.

Signed (Patient or Guardian) _____ Date _____

All bills are ultimately the responsibility of the patient. We will file insurance claims as noted, however, if your insurance has not paid in 60 days, the bill is due and payment by you is expected immediately.

COMPREHENSIVE PATIENT HISTORY

Please complete the following two pages.

Patient Name: _____ Date of Birth: _____ Soc. Sec. #: _____

Occupation _____ List all previous occupations: _____

Birth place: _____ List all States/Countries visited: _____

What is the reason for today's visit? _____ Today's Date: _____

Describe the following (if applicable):

Location of problem: _____ How long have you had this problem? _____

How severe is this problem? ☐ Mild ☐ Moderate ☐ Very How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

When was your last complete physical examination? _____ Where? _____

PERSONAL HISTORY:

ILLNESSES: Have you ever had:					
Measles	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No		
Chicken pox	☐ Yes ☐ No	Meningitis	☐ Yes ☐ No		
Whooping cough	☐ Yes ☐ No	Anemia/jaundice	☐ Yes ☐ No		
Scarlet fever	☐ Yes ☐ No	Migraine headaches	☐ Yes ☐ No		
Pneumonia	☐ Yes ☐ No	Diabetes or cancer	☐ Yes ☐ No		
		Asthma/emphysem	☐ Yes ☐ No		

INJURIES: Have you ever had:	
Broken bones	☐ Yes ☐ No
Sprains/dislocations	☐ Yes ☐ No
Lacerations (extensive)	☐ Yes ☐ No
Concussion/head injury	☐ Yes ☐ No
Ever been knocked out	☐ Yes ☐ No

SURGERY: List previous hospitalizations/serious injuries: When?

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

ALLERGIES: List any (food, drug, other):

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily: _____

Use of tobacco: ☐ Never ☐ Previously but quit ☐ Current packs per day: _____

Drug use: ☐ Never ☐ Type/Frequency: _____

Excessive exposure at home/work ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

Caffeine use: How many cups coffee/tea/soda per day? _____

Regular exercise: How often? _____

MEDICATIONS: List all regularly taken:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you get regular flu shots? ☐ Yes ☐ No

Last Tetanus _____

Last Pneumonia _____

FAMILY HISTORY					
Cancer	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Heart trouble	☐ Yes ☐ No
Acute Infections	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Bleeding Tendency	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No	Hereditary Defects	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Asthma/emphysem	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
		Mental Illness	☐ Yes ☐ No	Congenital Deformities	☐ Yes ☐ No

Patient History Continued:

FAMILY HISTORY:	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Brother or Sister			
Spouse			
Children			

PLEASE ANSWER ALL QUESTIONS ***Have you recently experienced any of the following?***

GENERAL HEALTH & WELL-BEING

Good general health lately	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

EYES

Eye disease or injury	☐ Yes	☐ No
Wearing glasses/contact lens	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

EARS, NOSE, THROAT, SINUS

Hearing loss	☐ Yes	☐ No
Ringing in the ears	☐ Yes	☐ No
Perforated (hole in) ear drums	☐ Yes	☐ No
Earaches or drainage		
Sinus problems	☐ Yes	☐ No
Seasonal nasal discharge (allergies)	☐ Yes	☐ No
Loss of smell	☐ Yes	☐ No
Nose bleed	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Bad breath or bad taste	☐ Yes	☐ No
Sore throat or voice change	☐ Yes	☐ No
Swollen glands in neck	☐ Yes	☐ No

HEART & CIRCULATORY SYSTEM

Heart trouble	☐ Yes	☐ No
Chest pains	☐ Yes	☐ No
Palpitations or flutter of heart	☐ Yes	☐ No
Swelling of feet, ankles or hands	☐ Yes	☐ No
Shortness of breath that awakens you at night	☐ Yes	☐ No
Cramping in legs	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No

LUNGS

Frequent coughing	☐ Yes	☐ No
Spitting up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No

GENITOURINARY

Frequent urination (voiding)	☐ Yes	☐ No
Burning or painful urination	☐ Yes	☐ No
Blood in urine or discoloration	☐ Yes	☐ No
Change in force or strain when urinating	☐ Yes	☐ No
Inability to control bladder or dribbling	☐ Yes	☐ No
Getting up at night to pass urine	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Male – testicle pain	☐ Yes	☐ No

GASTROINTESTINAL

Loss of appetite	☐ Yes	☐ No
Change in bowel movements	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Heartburn or chronic indigestion	☐ Yes	☐ No
Frequent diarrhea	☐ Yes	☐ No
Painful bowel movements or constipation	☐ Yes	☐ No
Red blood cells in stool or tarry, black stools	☐ Yes	☐ No
Stomach pain	☐ Yes	☐ No
Hemorrhoids or rectal itching	☐ Yes	☐ No

BONES, JOINTS, MUSCLES

Joint pain, stiffness, or swelling	☐ Yes	☐ No
Weakness of muscles or joints	☐ Yes	☐ No
Muscle pain or cramps	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Cold extremities (legs)	☐ Yes	☐ No
Difficulty in walking	☐ Yes	☐ No

SKIN

Rash or itching	☐ Yes	☐ No
Change in skin color	☐ Yes	☐ No
Change in hair or nails	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Breast pain	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No

BRAIN & NERVOUS SYSTEM

Frequent or recurring headaches	☐ Yes	☐ No
Light headed or dizzy	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Numbness or tingling sensations	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Temporary blindness	☐ Yes	☐ No
Loss of consciousness	☐ Yes	☐ No
Weakness of any extremity (leg or arm)	☐ Yes	☐ No

MENTAL HEALTH

Memory loss or confusion	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Sleep problems	☐ Yes	☐ No

ENDOCRINE

Glandular or hormone problem	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Excessive thirst or urination	☐ Yes	☐ No
Heat or cold intolerance	☐ Yes	☐ No
Dry skin	☐ Yes	☐ No
Change in hat or glove size	☐ Yes	☐ No

BLOOD & LYMPH

Slow to heal after cuts	☐ Yes	☐ No
Easily bruise or bleed	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Past transfusion	☐ Yes	☐ No
Enlarge glands	☐ Yes	☐ No

WOMEN ONLY:

Pain with periods	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No

pregnancies: # miscarriages:

Date of last PAP smear? _____

Finding of last PAP: ☐ Normal ☐ Abnormal

Date of last period? _____

Date of last Mammogram? _____

Do you practice birth control? ☐ Yes ☐ No

If so, what type:

Patient's Signature: _____ **Date:** _____

☐ *I have reviewed and confirmed this information with the patient.* **Provider Signature:**

Today's Date _____ _____