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Patient Initial Visit Questionnaire

Contact Information

Name:		SSN:
Street Address:		City:
State:	Zip Code:	Home Phone:
Work Phone:	Fax:	E-mail:
Date of Birth:	Age:	Sex:
Emergency Contact Name:		Emergency Contact Phone:

Referral Information

Referred by: <input type="checkbox"/> Self-referred <input type="checkbox"/> St. Joseph Medical Center <input type="checkbox"/> Encino-Tarzana Medical Center <input type="checkbox"/> Physician (Complete information below) <input type="checkbox"/> Other:		
Name of Referring Physician:		Specialty:
Street Address:		City:
State:	Zip Code:	Phone:

Insurance Information

Insurance Carrier:		Phone:
Claim Address:		
Policy Number:	Group Number:	
Name of Insured:	Relationship to Patient:	

I authorize payment of medical benefits billed to my insurance to my physician.

Completed by: _____ Signature: _____ Date: _____

Past Medical History**Past Surgical History**

All medical conditions with which you have been diagnosed:	Name and date of all surgeries or procedures:

Current Medications

(Including vitamins and herbal medications)

Medication Name	Dose & Frequency	Start Date

Medication Allergies

Medication Name	Type of Reaction

Social History

Occupation:	Marital Status:
Do you use any recreational drugs?	
Do you drink any alcohol?	Amount:
Do you smoke any cigarettes?	Amount: When did you quit smoking:

Family History

List any medical problems that are common in your family and the relationship of the person with the condition:

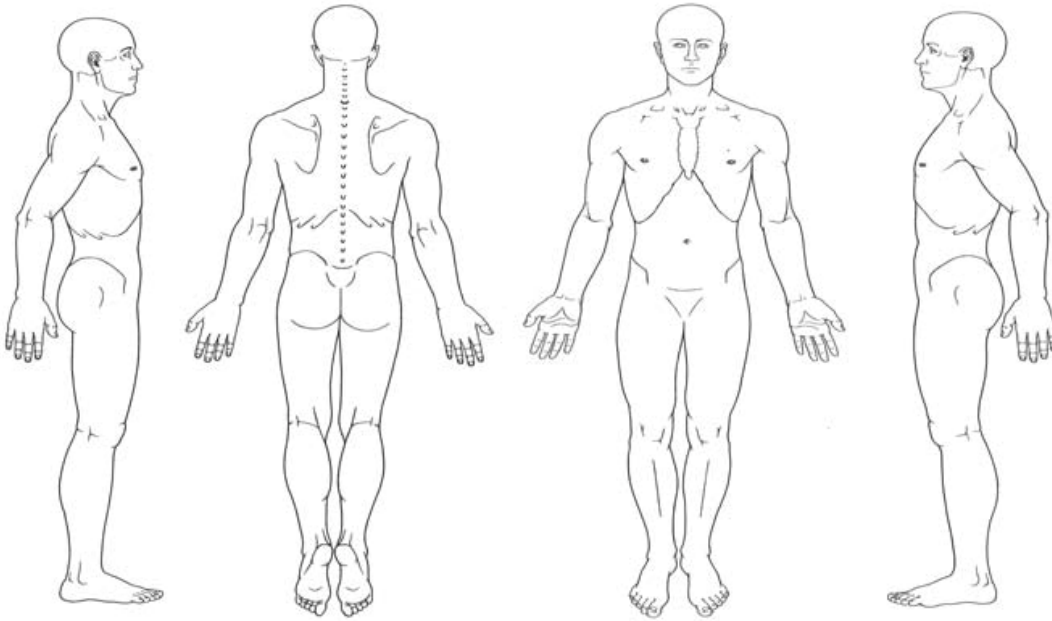
Review of Systems

Please indicate any of the conditions that apply or indicate other symptoms:			
General:	<input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight change <input type="checkbox"/> Nausea	Other:	<input type="checkbox"/> None
Ears:	<input type="checkbox"/> Ringing <input type="checkbox"/> Dizziness <input type="checkbox"/> Pain <input type="checkbox"/> Hearing loss	Other:	<input type="checkbox"/> None
Eyes:	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Visual loss <input type="checkbox"/> Double vision	Other:	<input type="checkbox"/> None
Mouth & Throat:	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Pain <input type="checkbox"/> Hoarseness	Other:	<input type="checkbox"/> None
Cardiovascular:	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations	Other:	<input type="checkbox"/> None
Respiratory:	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough	Other:	<input type="checkbox"/> None
Gastrointestinal:	<input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal pain	Other:	<input type="checkbox"/> None
Genitourinary:	<input type="checkbox"/> Burning on urination <input type="checkbox"/> Frequent urination	Other:	<input type="checkbox"/> None
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> Mania	Other:	<input type="checkbox"/> None
Endocrine:	<input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive thirst	Other:	<input type="checkbox"/> None
Neurologic:	<input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Headaches	Other:	<input type="checkbox"/> None
Musculoskeletal:	<input type="checkbox"/> Joint pain <input type="checkbox"/> Frequent fractures	Other:	<input type="checkbox"/> None
Skin:	<input type="checkbox"/> Skin discoloration <input type="checkbox"/> Changing moles	Other:	<input type="checkbox"/> None
Hematologic:	<input type="checkbox"/> Anemia <input type="checkbox"/> Easy bruising	Other:	<input type="checkbox"/> None
Immunologic:	<input type="checkbox"/> Infections <input type="checkbox"/> Allergies	Other:	<input type="checkbox"/> None

Current Symptoms

Describe the nature, duration, and intensity of your current symptoms (the reason for your office visit today):

Indicate where you have pain, weakness, numbness, or other symptoms:



Indicate the name and date of any imaging or lab tests that you have had for evaluation of your symptoms:

Indicate the name and date of any treatments or procedures that you have had for your symptoms:

Additional Information

Please provide any additional information that you feel may be important for your physician to know: