

NEW PATIENT HEALTH HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):		<input type="checkbox"/> M. <input type="checkbox"/> F.	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Contact Phone:			
Address:			
Email:			
Previous or referring doctor:			Date of last physical exam:

Notice of Patient Privacy/Patient Consent Form

I understand that as part of my healthcare, the physicians of One to One Health originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

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Patient Signature

Date

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR (Measles, Mumps, Rubella)
List any medical problems that other doctors have diagnosed		
Surgeries		
Year	Reason	Hospital

Sample Medical History Write Up

R Pring



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