

PATIENT INFORMATION

PATIENT NAME:				MALE:	FEMALE:					
	Last	(Legal First)	Middle Initial							
ADDRESS:										
	Street	PO Box or Apt. #	City	State	Zip					
HOME PHONE: ()		MARITAL STATUS:	M S I	D W					
AGE: DATE	OF BIRTH:		SOCIAL SECURITY NUM	/IBER:						
EMAIL ADDRESS:										
How did you hear ab	oout our office?									
PATIENT'S EMPLO	OYER:		WORK PHONE:							
	RESPO	NSIBLE PARTY	/ BILLING INFORMATIO	ON						
NAME:	BIRTH	TH DATE:								
ADDRESS:			РНО	NE						
Street		or Apt. # City	State Zip							
<i>Consent to Evaluate and Treat:</i> I certify that I have rights to and do give the staff at STEP Therapies, Inc, it's doctors, and paraprofessional staff members to evaluate and treat with tests, examinations, or treatment they feel is necessary for this minor.										
Signed:		Relationship	(parent/guardian, etc.):		Date:					

NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU TO NOTIFY IN CASE OF EMERGENCY:

NAME: RELATIONSHIP: PHONE:

PATIENT HISTORY

Do you or have you ever consumed alcohol? Yes No If Yes, how much & how often: Scarlet Fever Yes No High Blood Pressure Yes No Skin Disorders Yes No Measles Yes No Heart Murmur Yes No Tumor, Cancer, Cysts Yes No German Measles Yes No Dizziness/Fainting Yes No Yes No Sugar in Urine Yes No	Last Name			First Name	Middle Initial				
Occupation:	Primary Care Physician: Dr.				Location:				
Do you have any knows allergies (drug)? YesNo If yes, Please list all known allergies:	Marital Status: M S	D	W S	EP					
Have you had treatment for this problem before? If so, what :	Occupation:								
Please list all of you current medications (name, dosage, and frequency), as well as over the counter medications: Please list all of you current medications (name, dosage, and frequency), as well as over the counter medications: Do you or have you ever smoked cigarettes, cigars or pipes? Yes No If Yes, how long? If Yes, how many packs per day?Age you started: If you have quit smoking, when was it?MonthYea Do you or have you ever consumed alcohol? Yes No If Yes, how much & how often:	Do you have any knows	allergie	es (dru	ng)? Yes No I	f yes, Please list	all kn	own allergies:		
Do you or have you ever smoked cigarettes, cigars or pipes? Yes No If Yes, how long? If Yes, how many packs per day?Age you started: If you have quit smoking, when was it?MonthYea Do you or have you ever consumed alcohol? Yes No If Yes, how much & how often: Scarlet Fever Yes No Measles Yes No Heart Murmur Yes No German Measles Yes No Heart Murmur Yes No Juintation Fever Yes No Heart Murmur Yes No German Measles Yes No Heart Murmur Yes No Starter Yes No Mumps Yes No Frequent Viniation Yes No Malaria Yes No Gum or Tooth Problems Yes No Gallbladder Disease Yes No Frequent Cloids Yes No Fye No Recurrent Headaches Yes No Recurrent Headaches Sinusitis Yes No Recurrent Diarnhea Yes No Fye No Recurrent Diarnhea Yes No Recurrent Diarnhea Yes No Recurrent Diarnhea <td>Have you had treatment</td> <td>for this</td> <td>probl</td> <td>em before? If so, what</td> <td>:</td> <td></td> <td></td> <td></td> <td></td>	Have you had treatment	for this	probl	em before? If so, what	:				
If Yes, how many packs per day? Age you started:If you have quit smoking, when was it?MonthYea Do you or have you ever consumed alcohol? YesNo If Yes, how much & how often:	Please list all of you curr	rent me	dicatio	ons (name, dosage, and	frequency), as	well as	over the counter medication	ions:	
If Yes, how many packs per day? Age you started:If you have quit smoking, when was it?MonthYea Do you or have you ever consumed alcohol? YesNo If Yes, how much & how often:									
Do you or have you ever consumed alcohol? YesNo If Yes, how much & how often: Scarlet Fever Yes No High Blood Pressure Yes No Skin Disorders Yes No Measles Yes No Heart Murmur Yes No Tumor, Cancer, Cysts Yes No German Measles Yes No Dizziness/Fainting Yes No Venereal Diseases Yes No Rheumatic Fever Yes No Insomnia Yes No Sugar in Urine Yes No Mumps Yes No Frequent Anxiety or Yes No Frequent Urination Yes No Malaria Yes No Recurrent Headaches Yes No FEMALES ONLY Venereal Disease Yes No Gum or Tooth Problems Yes No Recurrent Colds Yes No Frequent Periods Yes No Syster Touble Yes No Bloody Stools Yes No Severe Cramps Yes No Ear, Nose, Throat Yes No Recurrent Diarrhea Yes No IMMUNIZATIONS Head Injury Yes No Recent Weight Gain/ DPT Yes No Astima Yes No Recent Weight Gain/ DPT Yes No Shortness o			-				-		
Scarlet FeverYesNoHigh Blood PressureYesNoSkin DisordersYesNoMeaslesYesNoHeart MurmurYesNoTumor, Cancer, CystsYesNoGerman MeaslesYesNoDizziness/FaintingYesNoVenereal DiseasesYesNoRheumatic FeverYesNoWeakness/ParalysisYesNoSugar in UrineYesNoMumpsYesNoInsomniaYesNoFrequent UrinationYesNoMunpsYesNoFrequent Anxiety orYesNoPain in UrinationYesNoChicken PoxYesNoFrequent Anxiety orYesNoPain in UrinationYesNoMalariaYesNoRecurrent HeadachesYesNoInsomniaYesNoGum or Tooth ProblemsYesNoRecurrent ColdsYesNoSevere CrampsYesNoGarl or Tooth ProblemsYesNoGallbladder DiseaseYesNoExcessive flowYesNoEar, Nose, ThroatYesNoRecurrent DiarrheaYesNoMMRUNIZATIONSHead InjuryHead InjuryYesNoRecurrent DiarrheaYesNoMMR-Measles/MumpsYesNoHay Fever/AllergiesYesNoRecurrent DiarrheaYesNoDPTYesNoAsthmaYesNoRecent Weight Gain/DPTYesNo <td>If Yes, how many packs</td> <td>per day</td> <td>y?</td> <td>Age you started:</td> <td> If you have o</td> <td>quit sm</td> <td>noking, when was it?N</td> <td>Ionth</td> <td>_Yea</td>	If Yes, how many packs	per day	y?	Age you started:	If you have o	quit sm	noking, when was it?N	Ionth	_Yea
MeaslesYesNoHeart MurmurYesNoTumor, Cancer, CystsYesNoGerman MeaslesYesNoDizziness/FaintingYesNoVenereal DiseasesYesNoRheumatic FeverYesNoWeakness/ParalysisYesNoSugar in UrineYesNoMumpsYesNoInsomniaYesNoFrequent UrinationYesNoChicken PoxYesNoFrequent Anxiety orYesNoPain in UrinationYesNoMalariaYesNoRecurrent HeadachesYesNoFEMALES ONLYVesNoTuberculosisYesNoRecurrent ColdsYesNoIrregular PeriodsYesNoGum or Tooth ProblemsYesNoGallbladder DiseaseYesNoSevere CrampsYesNoEye TroubleYesNoBloody StoolsYesNoExcessive flowYesNoEar, Nose, ThroatYesNoStomach ProblemsYesNoMR-Measles/MumpsYesNoHad InjuryYesNoStomach ProblemsYesNoDPTYesNoShortness of BreathYesNoJoint DiseaseYesNoFlu ShotYesNoChest Pain/PressureYesNoJoint DiseaseYesNoFlu ShotYesNoChest Pain/PressureYesNoBack ProblemsYesNoFlu ShotYes	Do you or have you ever	consu	med al	cohol? Yes No	If Yes, how n	nuch &	z how often:		
German MeaslesYesNoDizziness/FaintingYesNoVenereal DiseasesYesNoRheumatic FeverYesNoWeakness/ParalysisYesNoSugar in UrineYesNoMumpsYesNoInsomniaYesNoFrequent UrinationYesNoChicken PoxYesNoFrequent Anxiety orYesNoPain in UrinationYesNoMalariaYesNoDepressionYesNoFEMALES ONLY	Scarlet Fever	Yes	No	High Blood Pressure	Yes	No	Skin Disorders	Yes	No
Rheumatic FeverYesNoWeakness/ParalysisYesNoSugar in UrineYesNoMumpsYesNoInsomniaYesNoFrequent UrinationYesNoChicken PoxYesNoFrequent Anxiety orYesNoPain in UrinationYesNoMalariaYesNoDepressionYesNoFEMALES ONLYYesNoTuberculosisYesNoRecurrent HeadachesYesNoNo. of PregnanciesYesNoGum or Tooth ProblemsYesNoRecurrent ColdsYesNoIrregular PeriodsYesNoSinusitisYesNoGallbladder DiseaseYesNoSevere CrampsYesNoEar, Nose, ThroatYesNoBloody StoolsYesNoIMMUNIZATIONSYesNoHead InjuryYesNoStomach ProblemsYesNoMR-Measles/MumpsYesNoHay Fever/AllergiesYesNoRecent Weight Gain/DPTYesNoShortness of BreathYesNoJoint DiseaseYesNoFlu ShotYesNoChronic CoughYesNoBack ProblemsYesNoPheumovaxYesNoRapid Heart Beat orYesNoNeck PainYesNoMammogramYesNoPalpitationsYesNoNeck PainYesNoFlexible SignoidoscopyYesNo <td>Measles</td> <td>Yes</td> <td>No</td> <td></td> <td>Yes</td> <td>No</td> <td>Tumor, Cancer, Cysts</td> <td>Yes</td> <td>No</td>	Measles	Yes	No		Yes	No	Tumor, Cancer, Cysts	Yes	No
MumpsYesNoInsomniaYesNoFrequent UrinationYesNoChicken PoxYesNoFrequent Anxiety orYesNoPain in UrinationYesNoMalariaYesNoDepressionYesNoFEMALES ONLYYesNoTuberculosisYesNoRecurrent HeadachesYesNoFEMALES ONLYYesNoGum or Tooth ProblemsYesNoRecurrent ColdsYesNoIrregular PeriodsYesNoSinusitisYesNoGallbladder DiseaseYesNoSevere CrampsYesNoEye TroubleYesNoBloody StoolsYesNoExcessive flowYesNoEar, Nose, ThroatYesNoJaundiceYesNoMMR-Measles/MumpsYesNoHead InjuryYesNoStomach ProblemsYesNoPolioYesNoHay Fever/AllergiesYesNoRecent Weight Gain/DPTYesNoShortness of BreathYesNoJoint DiseaseYesNoFlu ShotYesNoChronic CoughYesNoBack ProblemsYesNoPneumovaxYesNoRapid Heart Beat orYesNoNeck PainYesNoFlexible SignoidoscopyYesNoPalpitationsYesNoNeck PainYesNoFlexible SignoidoscopyYesNo	German Measles	Yes							
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Patient Signature:_____

Date Completed:_____