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MEDICAL INFORMATION FORM

PATIENT INFORMATION

Last Name | MI | First Name | Date of Birth | Gender ◯ M ◯ F

Address | City | State | Zip

EMERGENCY CONTACT

Name | Phone | Relation

Do/Did you Work? ◯ Yes ◯ No Profession

INSURANCE INFORMATION

Have Insurance? ◯ Yes ◯ No Name of Insurance carrier

Assignment of Insurance Benefits: I authorize my health insurance to make payments directly to Healthcare provider (JFD medical PLLC dba, Regional Lung and Sleep Clinic), and understand that I am financially responsible for all charges incurred that are not covered in full by the insurance. I also understand that it is my responsibility to notify my health insurance carrier if I enroll in another insurance plan; Otherwise I will be responsible for the payment.

Please bring insurance card to front desk **Signature:** Date of Birth

PAST MEDICAL CONDITIONS

CIRCLE or CHECK ✔ conditions that you have been diagnosed with in the past

☐ High BP ☐ Stroke ☐ Emphysema ☐ Congestive Heart Failure ☐ Atrial Fibrillation
☐ Arthritis ☐ High Cholestrol ☐ Seizures ☐ Heart Attack
☐ COPD ☐ Sleep Apnea ☐ Diabetes ☐ Asthma Other Conditions

FAMILY HISTORY

CIRCLE or CHECK ✔ conditions that run in your family

☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Cancer ☐ Other (specify)

SOCIAL HISTORY

Smoke ◯ No ◯ Yes How many packs daily? Quit? (when)

Alcohol ◯ No ◯ Yes How much average daily? ☐ Social Intake Only Other

Recreational Drugs ◯ No ◯ Yes CIRCLE or CHECK ✔ choice ☐ Heroine ☐ Cocaine ☐ Marijuana ☐ Bath Salts Last Used (when)

ALLERGIES

◯ None ◯ Yes List all known allergies here:

MEDICATIONS

	Name	Dose		Name	Dose		Name	Dose
1			4			7		
2			5			8		
3			6			9		

SYSTEM REVIEW

Please CIRCLE or CHECK ✔ other significant symptoms that you are suffering from. Enter additional symptoms not listed on the line below.

GENERAL ☐ Fever ☐ Weakness ☐ Weight Loss
SKIN ☐ Rash ☐ Itching ☐ Ulcers
NERVES ☐ Headache ☐ Dizziness ☐ Passing Out
LUNGS ☐ Shortess of Breath ☐ Cough
KIDNEYS ☐ Burning urination ☐ Frequency
STOMACH/BOWELS ☐ Nausea/Vomitting ☐ Diarrhea ☐ Abdominal Pain
BLOOD ☐ Anemia ☐ Swollen Glands ☐ Excessive Bleeding
ENT ☐ Earache ☐ Double Vision ☐ Nose Bleeds ☐ Sore Throat
GENITALS ☐ Discharge ☐ Dyspareunia ☐ Erectile Dysfunction ☐ Irreg Menses
HEART ☐ Chest Pain ☐ Palpitations
JOINT ☐ Joint Pain/Swelling ☐ Gout

Other Symtoms