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STURGESFAMILYPRACTICE.COM

FAMILY
STURGES
PRACTICE

PATIENT INFORMATION

NAME | DATE OF BIRTH

PREFERRED NAME | AGE | SSN

REFERRED BY | ☐ MALE ☐ FEMALE

STREET ADDRESS | HOME PHONE

CITY | STATE | ZIP | CELL PHONE

MARITAL STATUS (please check one):

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED | EMPLOYER

EMERGENCY CONTACT

NAME | PHONE

RELATIONSHIP

RESPONSIBLE BILLING PARTY

NAME | DATE OF BIRTH

STREET ADDRESS | PHONE

CITY | STATE | ZIP | RELATIONSHIP

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PRIMARY INSURANCE

NAME OF COMPANY	SUBSCRIBER'S NAME

SUBSCRIBER SSN	SUBSCRIBER ID	GROUP #

DATE OF BIRTH	EMPLOYER	RELATIONSHIP

SECONDARY INSURANCE

NAME OF COMPANY	SUBSCRIBER'S NAME

SUBSCRIBER SSN	SUBSCRIBER ID	GROUP #

DATE OF BIRTH	EMPLOYER	RELATIONSHIP

INSURANCE AUTHORIZATION AND ASSIGNMENT

To the best of my knowledge, all of this information is true and correct. I understand that I am to pay for all services rendered to me and that I am willing to make specific arrangements to pay whatever parts not covered by my insurance on a timely basis. (Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.) In order to control your cost of billings, we request that our charges for office visits be paid at the conclusion of each visit. I grant my physicians to mutually exchange medical information with my referring physician(s) and/or their associates, to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of portions of the patient's medical records to my insurance carrier or Medigap carrier. If this account is assigned to any attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to me or my dependent. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PATIENT NAME: _____ DATE: _____

Medicare Authorization Agreement: I request that payment of authorized Medicare benefits be made either to me or on my behalf to John A Sturges, MD, a Professional Corporation, for any services furnished to me by that physician/supplier.

PATIENT NAME: _____ DATE: _____

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PERSONAL HISTORY

DATE OF BIRTH

BIRTHPLACE

MARITAL STATUS (please check one):

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

HEALTH OF SPOUSE

OCCUPATION (AND ITS HAZARDS)

RESIDENCE OF PAST 5 YEARS

RECREATION & EXERCISE

OF TIMES PER WEEK

DO YOU:

	HOW OFTEN?:
☐ USE RECREATIONAL DRUGS	
☐ CONSUME ALCOHOL	
☐ USE TOBACCO QUIT DATE: _____	
☐ CONSUME TEA,COFFEE	

PLEASE LIST MEDICINES TAKEN REGULARLY

SUPPLEMENTS

PERSONAL PAST HISTORY (CHECK YES OR NO)

HAVE YOU EVER HAD:

Measles	☐ YES	☐ NO
Mumps	☐ YES	☐ NO
Polio	☐ YES	☐ NO
Scarlet fever	☐ YES	☐ NO
Meningitis	☐ YES	☐ NO
Infectious Mono	☐ YES	☐ NO
Valley fever	☐ YES	☐ NO
Exposure to TB	☐ YES	☐ NO
Hives	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Venereal disease	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Back trouble	☐ YES	☐ NO
Pneumonia	☐ YES	☐ NO
Bronchitis	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO
High BP	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Bleeding tendency	☐ YES	☐ NO
Hepatitis (jaundice)	☐ YES	☐ NO
Injection needle use	☐ YES	☐ NO
Ulcer	☐ YES	☐ NO
Hemorrhoids	☐ YES	☐ NO
Bladder infection	☐ YES	☐ NO
Kidney disease	☐ YES	☐ NO
High fever/sinusitis	☐ YES	☐ NO
Nose bleeds	☐ YES	☐ NO
Other	☐ YES	☐ NO

OPERATIONS

	☐ YES	☐ NO
Appendix	☐ YES	☐ NO
Gallbladder	☐ YES	☐ NO
Stomach	☐ YES	☐ NO
Breast	☐ YES	☐ NO
Uterus/ovary	☐ YES	☐ NO
Prostate	☐ YES	☐ NO
Hernia	☐ YES	☐ NO
Thyroid	☐ YES	☐ NO
Heart/Vascular	☐ YES	☐ NO
Back or Neck	☐ YES	☐ NO
Other	☐ YES	☐ NO

INJURIES

Head	☐ YES	☐ NO
Back	☐ YES	☐ NO
Neck	☐ YES	☐ NO
Broken bones	☐ YES	☐ NO
Other	☐ YES	☐ NO

ALLERGIES

	☐ YES	☐ NO
Penicillin	☐ YES	☐ NO
Sulfa	☐ YES	☐ NO
Other drugs:	☐ YES	☐ NO
☐ Foods	☐ YES	☐ NO
☐ Nuts	☐ YES	☐ NO
☐ Shellfish	☐ YES	☐ NO
Other:	☐ YES	☐ NO

_____

IMMUNIZATIONS

Childhood vaccines	☐ YES	☐ NO
Chicken pox	☐ YES	☐ NO
Guardasill/HPV	☐ YES	☐ NO
Tetanus	☐ YES	☐ NO
Pneumonia	☐ YES	☐ NO
Shingles	☐ YES	☐ NO

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HAVE YOU RECENTLY HAD THE FOLLOWING: (CHECK YES OR NO)

GENERAL
Fatigue ☐ YES ☐ NO
Market weight change ☐ YES ☐ NO
Night sweats ☐ YES ☐ NO
Persistent fever ☐ YES ☐ NO
Sensitivity to heat or cold ☐ YES ☐ NO

SKIN
Eruptions (rash) ☐ YES ☐ NO
Change in hair or nails ☐ YES ☐ NO

EYES
Trouble seeing ☐ YES ☐ NO
Eye pain ☐ YES ☐ NO
Double vision ☐ YES ☐ NO
Inflamed eyes ☐ YES ☐ NO

EARS
Loss of hearing ☐ YES ☐ NO
Ringing in ears ☐ YES ☐ NO

NOSE
Loss of smell ☐ YES ☐ NO
Frequent colds ☐ YES ☐ NO
Obstructions ☐ YES ☐ NO
Nosebleeds ☐ YES ☐ NO

MOUTH
Soreness of tongue or gums ☐ YES ☐ NO
Dental problems ☐ YES ☐ NO

THROAT
Postnasal drainage ☐ YES ☐ NO
Soreness ☐ YES ☐ NO
Hoarseness (or changed voice) ☐ YES ☐ NO

BREASTS
Lumps ☐ YES ☐ NO
Discharge ☐ YES ☐ NO

CARDIO-VASCULAR SYSTEM
Cough, persisting ☐ YES ☐ NO
Phlegm ☐ YES ☐ NO
Bloody sputum ☐ YES ☐ NO
Wheezing ☐ YES ☐ NO
Pain on breathing ☐ YES ☐ NO
Shortness of breath ☐ YES ☐ NO
Chest pain or discomfort ☐ YES ☐ NO
Difficulty breathing when lying down ☐ YES ☐ NO
Swelling of ankles ☐ YES ☐ NO
Bluish fingers or lips ☐ YES ☐ NO
High blood pressure ☐ YES ☐ NO
Palpitations ☐ YES ☐ NO
Vein trouble ☐ YES ☐ NO

DIGESTIVE SYSTEM
(indicate average food selection for each meal)
Breakfast: _____
Lunch: _____
Dinner: _____
Change in appetite ☐ YES ☐ NO
Difficulty swallowing ☐ YES ☐ NO
Heartburn ☐ YES ☐ NO
Excess gas/belching ☐ YES ☐ NO
Abdominal distress ☐ YES ☐ NO
Nausea/vomiting ☐ YES ☐ NO
Vomiting of blood ☐ YES ☐ NO
Rectal bleeding ☐ YES ☐ NO
Black stools ☐ YES ☐ NO
Dark urine ☐ YES ☐ NO
Constipation ☐ YES ☐ NO
Diarrhea ☐ YES ☐ NO
Hemorrhoids ☐ YES ☐ NO
Need for laxatives ☐ YES ☐ NO

GENITOURINARY SYSTEM
More frequent urination (day) ☐ YES ☐ NO
More frequent urination (night) ☐ YES ☐ NO
Feel need to urinate without much urine ☐ YES ☐ NO
Unable to hold urine ☐ YES ☐ NO
Pain or burning ☐ YES ☐ NO
Blood in urine ☐ YES ☐ NO
Impotence or lack of sex drive ☐ YES ☐ NO
Pain with intercourse ☐ YES ☐ NO

ENDOCRINE
Thyroid trouble ☐ YES ☐ NO
Adrenal trouble ☐ YES ☐ NO
Cortisol treatment (present or past) ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO

LOCOMOTOR
Muscle cramps ☐ YES ☐ NO
Muscle weakness ☐ YES ☐ NO
Joint pain or swelling ☐ YES ☐ NO
Stiffness ☐ YES ☐ NO
Deformity in joints ☐ YES ☐ NO

NERVOUS SYSTEM
Headaches ☐ YES ☐ NO
Dizziness ☐ YES ☐ NO
Fainting ☐ YES ☐ NO
Convulsions or seizures ☐ YES ☐ NO
Nervousness or anxiety ☐ YES ☐ NO
Depression ☐ YES ☐ NO
Sleepiness or insomnia ☐ YES ☐ NO
Memory loss ☐ YES ☐ NO
Poor coordination ☐ YES ☐ NO
Weakness or paralysis ☐ YES ☐ NO
Change in sensation ☐ YES ☐ NO

GYN-OB
Started menstruation at age: _____
Date of last period: _____
Flow:
- ☐ Light
- ☐ Normal
- ☐ Heavy

Pain with periods ☐ YES ☐ NO
Interval between periods: ____ days
Duration: ____ days
Date of last PAP test: _____
History of abnormal PAP ☐ YES ☐ NO
Number of pregnancies: _____
Date of last mammogram: _____

NAME: _____ DATE: _____

FAMILY STURGES PRACTICE

PERSONAL PAST HISTORY (CHECK YES OR NO)

HAS ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING? (IF "YES," PLEASE INDICATE THEIR RELATIONSHIP TO YOU.)

Anemia	☐ YES	☐ NO	
Bleeding tendency	☐ YES	☐ NO	
Alcoholism (or other substance)	☐ YES	☐ NO	
Cholesterol	☐ YES	☐ NO	
Stroke	☐ YES	☐ NO	
Heart disease	☐ YES	☐ NO	
Diabetes	☐ YES	☐ NO	
High BP	☐ YES	☐ NO	
Kidney disease	☐ YES	☐ NO	
Asthma or Allergies	☐ YES	☐ NO	
Mental Illness	☐ YES	☐ NO	
Migraine headache	☐ YES	☐ NO	
Gout	☐ YES	☐ NO	
Weight problems	☐ YES	☐ NO	
Thyroid problems	☐ YES	☐ NO	
Arthritis	☐ YES	☐ NO	
Bowel problems	☐ YES	☐ NO	
Cancer (still living?)	☐ YES	☐ NO	

ADDITIONAL MEDICAL INFORMATION

Have you ever had a colonoscopy/endoscopy? ☐ YES ☐ NO

Date of last eye examination: _____

NAME

DATE OF BIRTH

PHONE NUMBER

DATE

FAMILY MEMBERS	PRESENT AGE OR AGE AT DEATH	CURRENT HEALTH (GOOD, FAIR, POOR) or IF DECEASED: CAUSE OF DEATH
Father		
Mother		
Siblings 1.		
2.		
3.		
4.		
5.		
6.		
Children 1.		
2.		
3.		
4.		
5.		
6.		