

PATIENT NAME: _____ DATE OF BIRTH: _____

Guy Rochman, MD

300 Mount Auburn Street SUITE 511
Cambridge MA 02138

PERSONAL AND CONFIDENTIAL
Fax Information to. 617 450-0051

DEMOGRAPHIC INFORMATION

Date: _____

Patient Name _____

Date of Birth (MM/DD/YYYY): _____ Sex: Male _____ Female _____

Telephone: Home: _____ Mobile: _____

Street Address. _____

City: _____ State: _____ Zip Code: _____

Email _____

Marital Status: Married _____ Single _____ Widow(er) _____ Divorced _____

Ethnicity: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number(s): _____

REFERRING PHYSICIAN

Name: _____ Telephone: _____

Address/Location _____

PRIMARY PHYSICIAN (if different from referring physician):

Name: _____ Telephone: _____

Address/Location _____

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MEDICAL INFORMATION

Height (inches) _____ Weight (pounds) _____ Weight Loss? Y N Amount _____

Tobacco Use: Y N Current Prior Amount/Day _____

Alcohol Us Y N Current Prior Amount/Day _____

Occupation: _____ # of Years: _____

Country of Residence: _____ # of Years: _____

Foreign Travel: Y N if yes, where and when: _____

FAMILY HISTORY (use other side of this sheet if necessary):

	Age	Living (Y or N)	Medical Condiitons
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any medical conditions in close blood relatives: (use other side of this sheet if necessary):

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MEDICAL INFORMATION

Allergies: Please list any allergies that you have with reaction:

Allergy	Type of Reaction
_____	_____
_____	_____
_____	_____

Medications: Please list all medications including hormone medications, herbal, vitamins etc.

Name of Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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REVIEW OF SYSTEMS: Please tell us if you have any of the following symptoms:

Constitutional:

- FEVER
- CHILLS
- NIGHT SWEATS
- HEADACHES
- WEIGHT GAIN

Cardiovascular:

- CHEST PAIN
- IRREGULAR BEATS
- PALPITATIONS
- VALVE PROBLEMS
- HEART MURMUR

Immunologic:

- HAY FEVER
- SKIN RASHES
- LYMPHATIC:
- SWOLLEN GLANDS
- SWELLING ARMS/LEGS

Respiratory:

- SHORTNESS OF BREATH
- PAIN BREATHING
- COUGH
- WHEEZING
- SPUTUM

Neurological:

- TREMORS
- DIZZINESS
- NUMBNESS
- STROKE
- TIA
- FAINTING SPELLS
- OTHER

Gastrointestinal:

- ABDOMINAL PAIN
- NAUSEA/VOMITING
- HEARTBURN
- SWALLOW DIFFICULTY
- JAUNDICE
- BLOOD IN STOOL
- DIARRHEA
- CONSTIPATION

Musculoskeletal:

- JOINTS HURT/STIFF
- BONE PAIN
- BACK/NECK PAIN
- WALKING DIFFICULTY

Hematological:

- ABNORMAL BLEEDING
- ABNORMAL BRUISING
- ANEMIA

Genitourinary:

- urinary pain
- URINARY FREQUENCY
- BLOOD IN URINE

Vascular:

- Ulcer/gangrene
- BLOOD CLOTS
- PAIN LEGS/FEET

Endocrine:

- Excessive thirst
- TOO HOT/COLD
- TIRED/SLUGGISH
- HOT FLASHES

Other: (use other side of this sheet if needed): _____

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PAST MEDICAL HISTORY

Please indicate any medical conditions that you have now or you have had in the past:

- | | | |
|--|--|--|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> GOUT | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ANEURYSM | <input type="checkbox"/> GERD | <input type="checkbox"/> PANCREATITIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> CANCER | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> BLADDER INFECTION | <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> OBESITY |
| <input type="checkbox"/> SEIZURES | <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> TUBERCULOSIS | |
| <input type="checkbox"/> OTHER (PLEASE DESCRIBE) _____ | | |

PAST SURGICAL HISTORY: (use other side of this sheet if needed):

List all previous surgeries and when performed:

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MEDICAL INFORMATION

IF FEMALE:

AGE AT FIRST MENSTRUAL PERIOD: _____ AGE AT MENOPAUSE: _____ # OF PREGNANCIES: _____ # OF CHILDREN: _____

DATE OF LAST PAP SMEAR: _____ DATE OF LAST MAMMOGRAM: _____

SIGNIFICANT GYNECOLOGICAL HISTORY: _____

IF MALE:

DATE OF LAST PROSTATE EXAMINATION: _____

SIGNIFICANT GENITOURINARY HISTORY: _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

NOTES