PATIENT INFORMATION FORM

JUSTIN YOVINO M.D., P.A.

DATE: ___________________

LAST NAME ______________________________________ FIRST ____ MI___________

DATE OF BIRTH _____________________ AGE ________ SS # ______________________________ SEX_____________

ADDRESS ____

CITY _______________________________________ STATE ____________________________ ZIP _________________________

HOME PHONE ______________________________________ WORK PHONE ____

OUT OF STATE ADDRESS ____

EMAIL ADDRESS____

MARITAL STATUS ________ Married (How Long? _____) ____Divorced (How Long?) ______
________ Widowed (How Long? _____) ____Single

LIVE WITH _____ Family/Husband ______ Alone _____Friend (s)/Roommate

PATIENT/SPOUSE ____

ADDRESS ____

CITY ___________________________________ STATE _________________________________ ZIP ______________________

HOME PHONE ______________________________________ WORK PHONE ____

WHO REFERRED YOU TO OUR OFFICE? ____

INSURANCE COMPANY ____

ADDRESS ____

ID NO _________________________________ GROUP NO. ___________________________________

SUBSCRIBER ____
(name on insurance policy)

OCCUPATION ______ Self – Employed (Type of business: ____)
______ Employed (Job title: ____)
_______Unemployed (Former job/occupation:____)
_______Retired (Former occupation: ____)
_______Student (Name of school/major: ____)
_______Housewife

PATIENTS EMPLOYER____ PHONE NO. _______________________________
SUBSCRIBER'S EMPLOYER _______________________________________ PHONE NO. _______________________________

IF INJURY, DATE OF ACCIDENT _____________ DO YOU HAVE AN ATTORNEY FOR THIS PROBLEM? _________________

ATTORNEY'S NAME ____

REASON FOR SEEING DR. YOVINO FOR TODAY ____
____
____
____

MEDICAL HISTORY

JUSTIN YOVINO, M.D., P.A.

DATE: ________________

PATIENT'S LAST NAME: ____________________ FIRST NAME: ____________________

FAMILY DOCTOR: ____________________ LAST PHYSICAL EXAM: ______________

DOCTORS NOTES:

____

MEDICAL HISTORY: Do you now, or have you ever, suffered from the following?

_____ Diabetes
_____ Hepatitis
_____ Emphysema
_____ None
_____ High Blood Pressure
_____ Heart Disease
_____ Epilepsy
_____ Other (please explain) ________________________
_____ Asthma
_____ Cancer
_____ Anxiety/Depression

SURGICAL HISTORY: List all the operations you have had:

_____ Appendectomy
_____ Hysterectomy
_____ C-Section
_____None
_____ Tonsillectomy/Adenoidectomy
_____ Cholecystectomy (gallbladder)
_____ Other (Please list): ____________________
____

ALLERGIES: have you ever had an adverse reaction (rash, swelling, difficulty breathing) to a drug or medication?

_____ Penicillin (Describe reaction: ____________________________)
_____ Other Drugs (Name: ____________________________)
_____ None (Describe reaction: ____________________________)

MEDICATIONS: List all drugs or medications that you are taking now or have taken in the last two weeks.

_____ Aspirin
_____ None
_____ Birth control pills
_____ Other(s) Please list: ________________________________
____
____
_____ Vitamins

TOBACCO:

_____ Never smoked
_____ Quit Smoking (When? ______ Packs per day? ______ Years? _________)
_____ Current smoker (Packs per day? ____________________ Years? _________)
_____ Cigar or pipe smoker (How many per day? __________________________)

ALCOHOL:

_____ Never Drink
_____ Very rare social drinking
_____ Beer (Bottles/cans per day?__________ Week? __________________)
_____ Wine (Glasses per day? _____________ Bottles per week? ___________)
_____ Other (_______________ Ounces per day? _______ Week? ___________)