Mercedes Montealegre, MD
Adult Patient History Form (≥13 years)

Sex: *M / F* DOB (mm/dd/yyyy): ____/____/________ SS#: ______-____-________

Last Name: ______________________ First Name:_________________ MI: ___

Address: ____

City: _______________________ State: ________ Zip: _______________

Home Phone: ______-______-________ Work Phone: ______-______-________

Fax: ______-______-________ e-mail address: ______________________________

Employer's Name or School Name: ____

Spouse's Name: ____

Emergency Contact Name: ____

Emergency Contact Phone: ______-______-________

Preferred Pharmacy: ____

How you found our practice: ____

Insurance Plan Name: ______________________________ ID #: __________________

Insured's Name: ____

Secondary Plan Name: _____________________________ ID #: ___________________

Relationship to Insured: *Self / Child / Spouse / Other*

Photograph Identification Authorization

In order to help us be better acquainted with you we would like to take a picture of you in our office. It will be kept in your medical record chart for identification only. If the need for you to call us shall arise, this picture will allow us to easily put a face with your name.

_____________________________(My signature is my consent to a portrait –type photo for staff ID use only.)

HISTORY & PHYSICAL

DATE

NAME — M / F — MARITAL STATUS: S | M | W | D | SEP — DATE OF BIRTH

ADDRESS — PHONE (H) — (O)

OCCUPATION/ EMPLOYER — INSURANCE

PAGE #

CHART #

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Thyroid disease	11) Osteoporosis	16) Lipid disorder
2) Migraine	7) Hay fever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) Hypertension	20)

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING			ALLERGIES	VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
				Tetanus / Td		Rectal / Stool	
			SUPPLEMENTS	Influenza (flu)		Cholesterol	
				Pneumonia		Eye	
				Hepatitis		Dental	
				Tuberculosis			

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM

- ☐ Hearing problems ☐ Ringing in ear
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Vision problems ☐ Eye pain
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath: ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain ☐ Cold numb feet
- ☐ Varicose veins / Phlebitis
- ☐ Loss of appetite ☐ Difficulty swallowing

- ☐ Heartburn ☐ Peptic ulcer
- ☐ Nausea / Vomiting ☐ Gallbladder dis
- ☐ Abdominal pain- *chronic*
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive Bladder
  - ☐ Overnight > than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections ☐ Prostate prob
- ☐ Weight-loss - ☐ gain ☐ Height loss
- ☐ Appetite ☐ Nutrition problems
- ☐ Anemia ☐ Bruise easily
- ☐ Cancer ☐ Easily fatigued

- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Concentration prob ☐ Sleep problems
- ☐ Depression ☐ Nervousness
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Memory loss ☐ Mental illness
- ☐ Rheumatic Fever ☐ Measles
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Tuberculosis ☐ German measles
- ☐ Herpes ☐ Aids / HIV ☐ STD
- ☐ Sexual problems / enjoyment

- ☐ Decreased life enjoyment
- ☐ Decreased work performance
- ☐ Alcohol ____ oz. per week
- ☐ Coffee / Tea ____ cups per day
- ☐ Smoking- cig/day ___ # years ___ year quit ____
- ☐ Exercise
- ☐ Street Drugs

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of flow ____ Length of cycle ____

Date -1st day of last period ____

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ____ Abortions ____

Miscarriages ____ Live births ____

Birth control method ____

☐ Flushing / Menopause

Date of last PAP test ____

☐ Normal ☐ Abnormal

Date of last mammogram

☐ Normal ☐ Abnormal

SYNOPSIS

Authorization & Agreement for Medical Treatment

PATIENT NAME: ____

The undersigned hereby makes the following Acknowledgement and Agreement regarding the medical treatment to be provided to the patient whose name appears above.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Dr. Mercedes Montealegre, M.D. and his associates. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician.

AGREEMENT FOR PAYMENT: For and in consideration of the care and treatment provided to the patient, I promise to pay all charges for services rendered to the patient listed above.

INSURANCE BENEFITS: For the patient with accepted insurance: I hereby authorize my insurance benefits to be paid directly to Mercedes Montealegre, M.D. I understand that insurance is considered a means of reimbursing the patient for fees paid to the physician and is not a substitute of payment. I also understand that I am financially responsible for non-covered services, all deductibles, my co-payment amount and any other amount that is not payable under my contract.

RELEASE OF INFORMATION: I hereby authorize Mercedes Montealegre, M.D. to release any information in the course of treatment to my insurance company or any physician needing this information.

COLLECTION OF ACCOUNT: I understand that if this account is assigned to an attorney for collection and/or suit, Mercedes Montealegre, M.D., shall be entitled to reasonable attorney's fees and cost of collection. Also, if any bad check is written I am responsible to come to the office with a money order or cash to redeem that check and if any added cost is incurred to Mercedes Montealegre, M.D., I agree to pay for those fees as well.

BROKEN OR MISSED APPOINTMENTS: I understand that I will be charged a fee of $25.00 for any appointment that is not cancelled within 24 hrs. After two (2) broken or missed appointments Dr. Mercedes Montealegre retains the right to discontinue elective treatment.

WE ACCEPT VISA, MASTERCARD, AMEX, DISCOVER, CASH AND CHECKS

____ ________________

SIGNATURE OF RESPONSIBLE PARTY DATE

I have received the Notice of Privacy Policies for Mercedes Montealegre, MD, PA

____ ________________

SIGNATURE DATE