Mercedes Montealegre, MD
Adult Patient History Form

Sex: *M / F* DOB (mm/dd/yyyy): ____/____/_____

Last Name: _____ First Name: _____ MI: ___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Cell phone: _____-_____-_____ e-mail: _____

Employer's Name or School Name: _____

Spouse's Name: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____-_____-_____

How you found our practice: _____

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.)

Symptom Questionnaire

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please rank each symptom's severity from zero (0) to five (5) (i.e., 0, 1, 2, 3, 4, 5)
0= you never experience the symptom
5= you experience the symptom severely and all the time

Dermatological

Dry Skin	__/5
Course Skin	__/5
Itchy Skin	__/5
Dry, course hair	__/5
Thinning/loss of hair	__/5
Thinning eyebrows	__/5
Brittle or ridges on nails	__/5
Excess wax in ears	__/5
Decreased sweat	__/5
Paleness of skin or lips	__/5
TOTAL	**__/50**

Metabolism

Lethargy (low energy)	__/5
Sensation of cold	__/5
Heat intolerance (not hot flashes)	__/5
Slow speech (non memory)	__/5
Weight gain with little food intake	__/5
Lack of appetite	__/5
Lack of libido	__/5
TOTAL	**__/30**

Dryness (sicca)

Dry eyes	__/5
Dry skin	__/5
Dry mouth	__/5
Dry nose	__/5
Dry sinuses	__/5
Dry vagina	__/5
TOTAL	**__/30**

Gastrointestinal

Constipation	__/5
Diarrhea	__/5
Irritable bowel syndrome	__/5
GERD (reflux disease)	__/5
TOTAL	**__/20**

Reproductive

Delayed menstrual flow	__/5
Excessive menstrual flow	__/5
Painful menses	__/5
Impotence (men only)	__/5
TOTAL	**__/20**

Mental/Emotional Well-being

Depression	__/5
Irritability/mood swings	__/5
Nervousness	__/5
Anxiety	__/5
Impaired memory	__/5
Impaired focus	__/5
TOTAL	**__/30**

Cardiovascular/Respiratory

Chest pain	__/5
Palpitations	__/5
Atrial fibrillation	__/5
Chronic cough of *unknown reason*	__/5
Airflow obstruction (non smokers)	__/5
Shortness of breath on physical exertion	__/5
Shortness of breath in general	__/5
TOTAL	**__/30**

Swelling

Swollen ankles	__/5
Swollen wrists	__/5
Swollen eyelids	__/5
Swollen, thick tongue	__/5
Swollen face	__/5
TOTAL	**__/25**

Musculoskeletal

Muscle weakness	__/5
Unexplained tingling or Numbness	__/5
Body aches	__/5
Muscle pain	__/5
Joint pain	__/5
Carpal tunnel syndrome	__/5
Plantar fasciitis	__/5
TOTAL	**__/35**

Sleep

Difficulty getting to sleep	__/5
Difficulty staying asleep	__/5
Wake unrefreshed	__/5
Sleep apnea	__/5
Snoring	__/5
TOTAL	**__/25**

Past Medical Diagnosis of:

__Hypertension
__High cholesterol
__Infertility/Multiple miscarriage
__Anemia
__Hypothyroidism
__Thyroid Nodules
__Goiter
__Hashimoto's thyroiditis
__Fibromyalgia
__Chronic Fatigue Syndrome
__Lupus
__Diabetes Type I
__Insulin resistance
__Celiac's disease
__Multiple Sclerosis
__Rheumatoid arthritis
__Srogren's disease
__Positive ANA
__Polycystic Ovarian Syndrome
__Live, work, or grow up near a nuclear power plant
__Currently taking Lithium or amiodarone (Cordarone)

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.

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 $30.00 for any appointment that is not cancelled within 48 hrs.** After two (2) broken or missed appointments Dr. Mercedes Montealegre retains the right to discontinue elective treatment.

OFFICE CREDIT ONLY NO REFUNDS

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

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

_____ _____

SIGNATURE DATE