DC IGLAS SEARS, M.D.

PATIENT IN RMATION FOR MEDICAL RECORDS

Nai e: ______ First ______ Last ______ Home phone: ( ) ______

Married 1☐ 2☐ 3☐ Single☐

Ad ess: ______ Divorced☐ Separated☐ Widowed☐

______ City ______ Zip code

Edi ational Level: ______ Date of birth: ______

Em loyed By: ______ Unemployed ☐ Age: ______

Wc c Address: ______ Drivers Lic. #______

______ City ______ Zip code Time in current Job ______ Mo or Yr(s)

Oc ipation: ______ Work phone: ( ) ______

Wl Referred You To This Office: ______ Social Sec.#______

Sp ise/Parent (Name): ______ Home phone: ( ) ______

Ac ress: ______ Work phone: ( ) ______

______ City ______ Zip code Social Sec.# ______

En loyed By: ______ Occupation: ______

PE SONAL MEDICAL HISTORY:

Dc /ou receive regular medical care from a physician or clinic? ☐ No ☐ Yes

Na ie of Physician or Clinic: ______ Phone: ( ) ______

Hi e you had any of the following illnesses ?

	No	Yes		No	Yes
High Blood Pressure	☐	☐	Epilepsy	☐	☐
Diabetes	☐	☐	Headaches	☐	☐
Cancer	☐	☐	Stomach Ulcers	☐	☐
Thyroid Disease	☐	☐	Stroke	☐	☐
Other Hormone Problem	☐	☐	Asthma	☐	☐
Heart Disease	☐	☐	Birth Defects	☐	☐
Kidney Disease	☐	☐	Concussion or Head Injury	☐	☐

H ve you had any other disease? ☐No ☐Yes If yes , Explain: ______

______

V iat is your current weight? Lbs.______ Highest weight ever ?______ Lbs. When ? ______

C n you explain any recent weight loss or weight gain ? ______

Have you recently had any of the following tests ?

	No	Yes	When	Results
Physical Exam				
Blood Tests				
Electrocardigram (EKG)				
Brain Scan / Cat Scan				
EEG				

Do you have any allergies ?

	No	Yes	How are you affected
Penicillin			
Other Medication			

Are you in the habit of using any of the following items ?

	Amount Currently Using	Most Ever Used
Coffee/Tea/Cola (cups per day)		
Cigarettes (packs per day)		
Alcohol (amount and types used)		
Vitamins		
Laxatives		
Sleeping Pills		

Are you currently on any medication ? ☐ No ☐ Yes If yes , please give name and dosage

Have you used any of the following medications ? (circle the ones used)

	No	Yes	When	How Much
Dilantin, Tegretol, Depokane,				
L-Dopa, Cogentin, Artane, Symmetrel, Deprenyl				
Valium, Xanax, Klonopin, Librium Serax, Dalmane				
Tranxene, Ativan, Meprobamate				
Nardil, Marplan, Parnate				
Elavil, Tofranil, Sinequan, Aventyl, Pamelor				
Desyrel, Norpramine, Triavil, Prozac, Zoloft				
Lithium				
Thorazine, Mellaril, Stelazine, Navane, Haldol, Prolixin				
Loxitane, Moban, Serentil, Trilafon				

PE SONAL PSYCHIATRIC HISTORY:

H ve you ever received psychiatric or psychological evaluation or treatment ? ☐ No ☐ Yes

Year	Doctor's Name	Reason	Medication Used (if any)

I ve you ever attempted suicide in the past? ☐ No ☐ Yes If yes complete the following :

Year	How did you attempt suicide ?	What happened

I ve you ever been Hospitilized past? ☐ No ☐ Yes If yes complete the following :

Year	Hospital	Reason for admission

amily History:

Example: Mother's sister S/B

	Mother			Father			Siblings					Children				Spouse	
	S/B	S/B	S/B	S/B	S/B	S/B	S/B	S/B	S/B	S/B	S/B	1	2	3	4	1	2
e (if deceased give date and age at death)																	
ncer																	
abetes																	
gh Blood Pressure																	
oke																	
eart Attack or Heart Trouble																	
ilepsy or Convulsions																	
ychiatric Hospitalization																	
ervous Breakdown																	
epression																	
vere Anxiety																	
ack Sheep																	
uicide or Suicide Attempt																	
lcohol Abuse																	
rug Abuse																	
roblems With the Law																	
irth Defects or Genetic Disorders																	
hyroid Problem																	
ther Hormone Problem																	
figraine Headaches																	

or Females Only:

Date your last menstrual period began: ______ Number of pregnancies: ______

Number of children born alive: ______ Number of therapeutic abortions: ______

Number of miscarriages or stillbirths: ______ Pap smear in the last year ? ☐ No ☐ Yes

Do you use any contraceptive methods? ☐ No ☐ Yes If Yes, what ? ______

Do you experience any changes in your mood associated with your menstrual cycle ? ☐ No ☐ Yes

If yes please explain : ______

Review of Your Current Health :

	No	Yes
Change in appetite	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐
Weakness or tiredness	☐	☐
Trouble sleeping	☐	☐
Depression	☐	☐
Suicidal thoughts	☐	☐
Problems with memory	☐	☐
Problems with concentration	☐	☐
Thyroid Disease	☐	☐
Double vision or poor vision	☐	☐
Sexual problems	☐	☐
Headaches	☐	☐
Asthma	☐	☐
Difficulty hearing	☐	☐
Fainting spells, blackout spells	☐	☐
Been denied life insurance	☐	☐
Chest pain	☐	☐
Spitting up blood	☐	☐
Shortness of breath at night	☐	☐
Shortness of breath with exercise	☐	☐
Palpitation or heart fluttering	☐	☐
Swelling of hands or feet	☐	☐
Visual hallucinations	☐	☐
Unusual excessive thirst	☐	☐
Urine problems, blood in urine	☐	☐
Indigestion, gas, heartburn	☐	☐
Stomach pain, stomach ulcer	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Vomiting	☐	☐
Blood in stool	☐	☐
Paralysis	☐	☐
Skin problem	☐	☐

Please describe or explain any of the positive answers above: ____________________

How do You Intend to Pay ? (check one) ☐ Cash ☐ Check ☐ Insurance ☐ Medicare ☐ Medical

Name of Insurance Co. ____________________ Phone: ( ) ____________

Address: ____________________ Policy # ____________

____________________ Group Name ____________
City Zip code

For Workman's Compensation Only :

Attorney (Name): ____________________ Phone: ( ) ____________

Address: ____________________
City Zip code

I, the undersigned, understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

I UNDERSTAND THAT I WILL BE CHARGED FOR ALL APPOINTMENTS IF I DO NOT GIVE AT LEAST 24 HRS NOTICE

Date ________ Signature ____________________ Parents Signature ____________________

ˌUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

'his authorization allows the healthcare provider(s) named below to release confidential medical ıformation and records. Note: *Information and records regarding treatment of minors, HIV, sychiatric/mental health conditions, or alcohol/substance abuse have special rules that require pecific authorization.*

ˌUTHORIZATION

hereby authorize: ______________________________
Physician/Healthcare Facility

'o release information regarding my medical history, illness or injury, consultation, prescriptions, reatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of ıail, fax or other electronic methods.

'o:

Name: DOUGLAS SEARS, MD, P.C.
16055 VENTURA BL. #670
ENCINO, CA 91436
Address: O: (818) 784-8481
F: (818) 784-8471

City ______ State ______ Zip Code ______

'he medical information/records will be used for the following purpose: Evaluation / Tx

'his authorization is:

[✓] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: ______________________

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse ________(initial) Tests for Antibodies to HIV ________(initial)
Psychiatric/Mental Health ________(initial) HIV Diagnosis/Treatment ________(initial)

)URATION This authorization shall be effective immediately and remain in effect until ________ Date

ˌESTRICTIONS

'ermissions for further use or disclosure of this medical information is not granted unless another uthorization is obtained from me or unless such disclosure is specifically required or permitted by law.

ˌ photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

have been advised of my right to receive a copy of this authorization.

______________________________ ______________________________
ʃignature of patient *or legal/personal representative* Relationship *if other than patient*

______________________________ ______________________________
'atient's Name (PRINT) Date

______________________________ ______________________________
'atient's Social Security Number Patient's Date of Birth

______________________________ ______________________________
Vitness name Witness signature