DR KEDY JAO

ANTI-AGING AND FAMILY MEDICINE

PATIENT PERSONAL INFORMATION

GENERAL

Last Name		First Name		Middle	
Home Address				APT	
City		State		Zip Code	
Home Phone		Cell Phone		Birthplace	
Date of Birth		Age		Sex	
Drivers License #		Email Address			
Marital Status		Spouse's Name			

Who may we THANK for referring you to us?		Phone	

EMPLOYMENT

Employer Name			Occupation		
Employer Address					
Employer City		Employer State		Employer Zip Code	
Employer Phone					

INSURANCE INFORMATION

Do you have medical insurance?		Is your insurance a PPO?	

PRIMARY INSURANCE (if you have insurance, otherwise leave blank)

Insurance Company		Group Number		Policy Number	
Insured's Name				Insured's DOB	
Relationship to Insured					

SECONDARY INSURANCE (if you have secondary insurance, otherwise leave blank)

Insurance Company		Group Number		Policy Number	
Insured's Name				Insured's DOB	
Relationship to Insured					

EMERGENCY CONTACT

Name		Relationship		Phone	

AUTHORIZATION

I understand that this office will submit claims to the listed insurance company, but that I am ultimately responsible for this account. I also authorize the release of any medical information necessary to process my claim.

Signature		Date	

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ROUTINE HEALTH ASSESSMENT - FAMILY/PERSONAL HISTORY

Name		Age		Date of Birth		Date	
Marital Status	Single Married Domestic Partner Divorced Widowed			Birth Place			

LIVING	MEDICAL CONDITIONS	DECEASED	CAUSE OF DEATH
Father: _____ Age		_____ Age at death	
Mother: _____ Age		_____ Age at death	
Sibling 1: _____ Age (Bros/Sis)		_____ Age at death	
Sibling 2: _____ Age (Bros/Sis)		_____ Age at death	
Child 1: _____ Age (M / F)		_____ Age at death	
Child 2: _____ Age (M / F)		_____ Age at death	

List blood relatives medical illnesses: *(eg Cancer, Leukemia, Diabetes, Hearth Trouble, High Blood Pressure, Stroke, Epilepsy, Thyroid, Alcoholism, Tuberculosis, Suicide)*

Relative:		Relative:	

SOCIAL HISTORY		
Education Level _______ yrs in High School, _______ yrs in College		
Do you use a seatbelt? Do you use a helmet?		
Do you smoke cigarettes? If so, _____ packs per day		
If you smoked in the past, for ______ years and I quit on _____/_____/_____		
Do you use: Cigars Pipe Chewing Tobacco Snuff		
Alcoholic Beverages: Never Rarely Moderate Daily		
Have you ever wanted help with alcohol now or in the past?	Y	N
Do you use recreational drugs?	Y	N
Do you or your partner use IV drugs?	Y	N
Have you ever wanted help with drugs now or in the past?	Y	N
Are you sexually active now? Vaginal Anal Oral		
Have you had more than 1, or a new, partner in the past year?	Y	N
Is/are your partner(s): Male Female Both		
Have you ever been hit or pushed by a partner?	Y	N
Do you take precautions against STD'S?	Y	N
Have you been put at risk for STD or HIV?	Y	N
Do you wish to have an HIV test?	Y	N
Have you ever had a tattoo?	Y	N
Do you have an Advance Directive (Living Will)?	Y	N
If not, would you like information?	Y	N

PAST MEDICAL HISTORY		
Any broken bones, dislocations or head injuries?	Y	N
Any serious accidents?	Y	N
SURGICAL HISTORY (Select all that apply)		
Tonsillectomy Appendectomy Hysterectomy		
Gall Bladder Removed Ovaries Removed Mastectomy		
Breast Lump Removed Other:___________________________		
Have you been hospitalized for any illness?	Y	N
If so, why?		
CONDITIONS (Select all that apply)		
Cancer High Blood Pressure Heart Disease Diabetes Depressions Lung Disease Arthritis or Rheumatism Migraines Anemia Jaundice/Liver Disease STDS Seizures/Convulsions Rheumatic Fever Meningitis Tuberculosis or + TB Test Any Bone or Joint Disease Kidney Disease Kidney Stones Hay Fever Measles Hives/Eczema Mumps Chicken Pox Whooping Cough Pneumonia Polio Freq Infections/Boils Skin Disease Freq Colds or Sore Throats Blood Transfusions		
Weight at age 18? ____ Maximum weight ____ When? _________		
PREGNANCY HISTORY		
# of Pregnancies ____ # Living Children ____ # of Deliveries ____ # of C-Sections ____ # of Abortions ____ # Miscarriages ____ # of Tubal Pregnancies ____ Any pregnancy complications? ____		

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ALERGIES	REACTION	MEDICATIONS (List strength and frequency)	
Penicillin or Sulfa		1)	
Erthromycin		2)	
Aspirin, Codeine, Morphine		3)	
Iodine		4)	
Adhesive Tape		5)	
Any foods or other drugs		6)	

CONSTITUTIONAL SYMPTOMS		
Fever	Y	N
Chills	Y	N
Night sweats	Y	N
Extreme tiredness	Y	N
Recent weight change	Y	N
Change in appetite	Y	N

EYES, EARS, NOSE & THROAT		
Blurred vision	Y	N
Double vision	Y	N
Ear pain	Y	N
Ringing in the ears	Y	N
Hearing loss	Y	N
Nasal discharge	Y	N
Sore throat	Y	N

CARDIOVASCULAR		
Chest pain	Y	N
Palpitations	Y	N
Hand/feet/ankle swelling	Y	N

RESPIRATORY		
Cough __chronic __frequent	Y	N
Coughing up blood	Y	N
Shortness of breath	Y	N
Stop breathing with sleep	Y	N

MUCULOSKELETAL		
Paint in joints	Y	N
Back pain	Y	N
Muscle pain	Y	N

GASTROINTESTINAL		
Stomach trouble or ulcer	Y	N
Nausea or vomitting	Y	N
Heartburn/indigestions	Y	N
Constipation	Y	N
Diarrhea	Y	N
Hemorrhoid/rectal bleed	Y	N
Black Stool	Y	N
Difficulty swallowing	Y	N
Do you take laxatives?	Y	N
Change in bowel habits	Y	N

GENITOURINARY		
Kidney disease or stones	Y	N
Painful urination	Y	N
Blood in urine	Y	N
Frequent urination	Y	N
Frequent urination at night	Y	N

SKIN		
Rash	Y	N
Itching	Y	N

HEMATOLOGIC		
Easy bleeding	Y	N

ENDOCRINE		
Abnormal thirst	Y	N
Excessive urine volume	Y	N
Eat excessively	Y	N
Hot flashes	Y	N
Thyroid problems	Y	N

NEUROLOGICAL		
Headache __Freqent __Severe	Y	N
Dizziness	Y	N
Numbness	Y	N
Paralysis	Y	N
Fainting	Y	N
Loss of consciousness	Y	N
Seizure	Y	N

MENTAL HEALTH		
Anxiety	Y	N
Hallucinations	Y	N
Treated for mental disorder	Y	N
Feeling down or depressed	Y	N
Lack interest/pleasure	Y	N

HABITS		
Trouble sleeping	Y	N
Exercise	Y	N

MEN ONLY		
Conduct testicular exams	Y	N
Erectile problems?	Y	N

WOMEN ONLY		
Conduct breast exams	Y	N
Date of last period		
Regular periods?	Y	N
Usual length length in days		
Cycle ______ days		
Pain or cramps	Y	N
Abnormal vaginal discharge	Y	N