DRS. KANE & DAVIS ASSOCIATES, LLC
COMPREHENSIVE MEDICAL HISTORY

DATE _____

NAME_____**DOB** _____

MALE ☐ **FEMALE** ☐ **HEIGHT**_____**WEIGHT**_____

PLEASE CHECK ALL THAT APPLY

RACE ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐White

ETHNIC CATEGORY: ☐Hispanic or Latino ☐Not-Hispanic or Latino

PREFERRED LANGUAGE _____

OCCUPATION_____

REFERRING PHYSICIAN_____

ALLERGIES_____

CHIEF COMPLAINT_____

SMOKING STATUS: SMOKER ☐YES ☐ NO
☐CURRENT DAILY SMOKER ☐OCCASIONAL SMOKER ☐FORMER SMOKER
☐NEVER SMOKED

OTHER TOBACCO PRODUCTS USED_____

ALCOHOL ☐YES ☐NO FREQUENCY:_____

DRUG USE ☐YES ☐NO _____

CAFFEINE ☐YES ☐NO DAILY INTAKE_____

SURGICAL HISTORY & DATE		MEDICAL HISTORY	FAMILY HISTORY
_____	_____	_____	☐Diabetes_____
_____	_____	_____	☐High Blood Pressure_____
_____	_____	_____	☐Stroke_____
_____	_____	_____	☐Heart Attack_____
_____	_____	_____	☐Cancer_____
_____	_____	_____	☐Asthma_____

PREVIOUS HOSPITALIZATIONS

REASON_____DATE_____HOSPITAL_____
REASON_____DATE_____HOSPITAL_____
REASON_____DATE_____HOSPITAL_____

CURRENT MEDICATIONS (Including Vitamins, Aspirin, etc.)

MEDICATION	DSG	MEDICATION	DSG	MEDICATION	DSG

PHARMACY_____LOCATION_____PHONE_____

CONSENT FOR RELEASE OF INFORMATION

I have read the NOTICE OF PRIVACY PRACTICES. I am aware the my "Protected Health Information" (PHI) will be disclosed to those physicians involved in my care, my insurance company(ies), business associates of the Practice, for the purpose of carrying out treatment, payment or health care operations. In addition, I have specified my references for routine uses and disclosures as indicated below:

Name_____DOB_____

Please indicate any and all of the following methods that would be appropriate for Drs. Kane & Davis Associates, LLC to contact you, should it be necessary:

☐ ADDRESS_____ ☐ EMAIL_____

☐ HOME #_____WORK #_____

☐ OTHER/CELL #_____FAX #_____

In the occasion that we do not contact you, it is suitable to leave a message (check all that apply)

☐ on answering machine ☐ with adult household member ☐ exclusively with patient

Who is authorized to receive patient medical/billing information? (check all that apply)

☐ patient only ☐ spouse ☐ family member (name)_____

☐ other (please specify)_____

I understand that further authorization (s) may be necessary as required by law should any additional disclosures of PHI be requested.

_____ _____

Signature of patient or personal representative (revised annually) Date

_____ _____

Printed name of patient or personal representative Description of personal representative's authority

_____

Revised Signature (Date) Revised Signature (Date) Revised Signature (Date)