

Hopkins Clinic
Confidential Patient Information

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Welcome to **HOPKINS CLINIC**. **Help us help you by completing this form. Please answer all the questions completely. All information provided is strictly confidential.** If you do not understand a question or are unsure of the information, please ask for assistance.

HEALTH HISTORY FORM

Name: _____ Age _____ Date of Birth ____/____/____

Do you have a **Primary Care Doctor**? Dr. _____ Phone? _____

Have you ever had?

- | | | | | |
|-------------------|--------------------|---------------------|--------------------|-------------------|
| chronic fatigue__ | stroke__ | gas problems__ | osteo arthritis__ | numbness__ |
| visual problems__ | vascular disease__ | vomiting__ | rheumatoid arth.__ | tingling__ |
| sinusitis__ | swollen ankles__ | constipation__ | gout__ | depression__ |
| ear aches__ | asthma__ | diarrhea__ | swollen joints__ | anxiety__ |
| pain swallowing__ | emphysema__ | rectal bleeding__ | rashes__ | bipolar__ |
| headaches__ | short of breath__ | liver disease__ | psoriasis__ | diabetes__ |
| migraines__ | lung problems__ | kidney disease__ | bruise easily__ | thyroid problem__ |
| heart disease__ | tuberculosis__ | bladder problem__ | melanoma__ | anemia__ |
| chest pain__ | ulcers__ | menstrual problem__ | cancer__ | allergies__ |
| hypertension__ | stomach pain__ | prostate problem__ | epilepsy__ | immune problem__ |

____ **NONE OF THE ABOVE**

MEDICAL ALLERGIES? (Penicillin, sulfur, etc?) **No / Yes** (Please list) _____

Are you regularly taking **over the counter** medications? **No** **Yes** **Please circle:** Vitamins Aspirin Tylenol Advil Aleve Antacids Laxative Allergy Sleep-aids Other: _____

Are you taking **Cortico-Steroids**? **No** **Yes** For what condition? _____

Are you regularly taking **prescription medications**? **No** **Yes** **For what condition?**

- | | | | | |
|---------------|------------------|-----------------|------------------|-------------|
| Allergy__ | Birth control__ | Chronic Pain__ | Hormones__ | Headaches__ |
| Antibiotics__ | Blood Pressure__ | Depression__ | Kidney disease__ | Migraines__ |
| Anxiety__ | Cancer__ | Diabetes__ | Osteoporosis__ | Clotting__ |
| Asthma__ | Cholesterol__ | Heart Disease__ | Indigestion__ | Epilepsy__ |

Please list names and dosage of medications: _____

Do you have any **intolerances or side effects** from any medications such as gas, nausea, gastritis, constipation, hives, etc.)? **None** _____

List any **SURGERIES** and the **date** of the surgery. **None** _____

List **broken bones**? **No / Yes** What and when? _____

Any **serious illnesses**? **No / Yes** What and when? _____

Any **hospitalizations**? **No / Yes** What and when? _____

List any PREVIOUS car or work accident / injury? No Yes... If yes, give **date** and briefly describe:

Are you?... Single Married Separated Divorced Widowed
 Highest level of education: GED High School ___ years of college

Are you a **student**? Part time Full Time

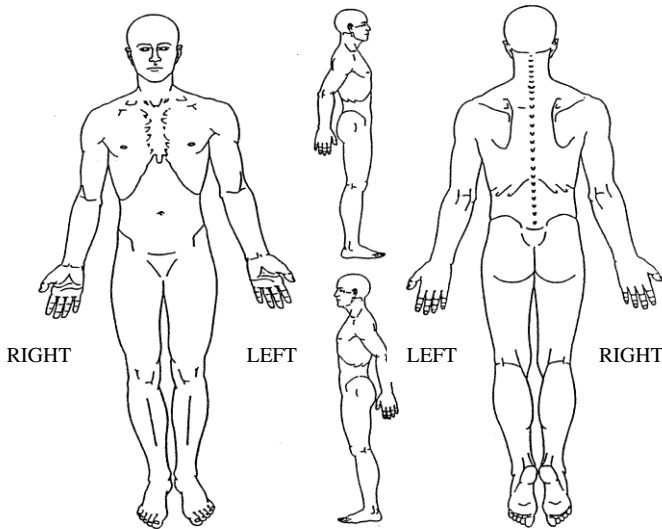
If **employed**, briefly describe your **occupation**: _____

If no longer working, **when and why did you stop**? _____

Do you use **tobacco**? Yes ___ No ___ Cigarettes: ___ pack per day for ___ years; Other _____

Do you drink **alcohol**? Yes ___ No ___ Daily ___ Weekly ___ Socially ___ Rarely ___

Draw or mark on the picture where you feel pain. You may write on the picture using words that describe your pain such as: Aches, sore, burning, tingling, numbness, sharp pain, shooting pain, etc. Mark areas of bruising or swelling



Please describe the problems you are having:

Check the activities below that are difficult or painful to do:

- | | | | |
|---|-----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Typing | <input type="checkbox"/> Climbing | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Writing | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Riding in car |
| <input type="checkbox"/> Tasting | <input type="checkbox"/> Grasping | <input type="checkbox"/> Bending | <input type="checkbox"/> Plane travel |
| <input type="checkbox"/> Smelling | <input type="checkbox"/> Holding | <input type="checkbox"/> Twisting | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Pinching | <input type="checkbox"/> Carrying | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Using the phone | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sexual Activity |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Leaning | <input type="checkbox"/> Pushing | <input type="checkbox"/> Reclining |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Walking | <input type="checkbox"/> Pulling | <input type="checkbox"/> Restful Sleeping |
| <input type="checkbox"/> Using the toilet | <input type="checkbox"/> Stooping | <input type="checkbox"/> Reaching | |
- Other _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

If the purpose of your visit today is related to injury sustained in an automobile accident, please answer the following questions. Please feel free to ask for help if you do not understand any of these questions.

Name: _____

Date of accident? _____ Location of accident (City/State) _____

Briefly describe how the accident occurred: _____

Were you the driver? YES___ NO___ If a passenger, were you in the front or back seat? _____

Were you wearing your seatbelt? YES___ NO___ Did the airbags deploy? YES___ NO___

Did you know the crash was about to happen? YES___ NO___ Did you brace for the impact? YES___ NO___

Did you get cut or scraped anywhere? YES___ NO___ Describe _____

Did you get bruised anywhere? YES___ NO___ Describe _____

Did you have any immediate pain? YES___ NO___ Describe _____

Did you hit your head? YES___ NO___ Did you lose consciousness? YES___ NO___

Did the police investigate the accident? YES___ NO___ Did an ambulance arrive? YES___ NO___

Did you go to the hospital by ambulance? YES___ NO___ What hospital? _____

Were you transported on a backboard YES___ NO___ with a neck collar in place? YES___ NO___

At the hospital, were you examined? YES___ NO___ Were x-rays taken? YES___ NO___

Was a CT scan performed? YES___ NO___ Was any laboratory work performed? YES___ NO___

Were you given prescriptions? YES___ NO___ for what? _____

Were you admitted to the hospital YES___ NO___ or released to see your own doctor? YES___ NO___

Were you referred to any other doctor? YES___ NO___ Who? _____

Have you been examined or treated by any other physician since the accident? YES___ NO___

Who? _____

What treatments have you received? _____
