Hopkins Clinic
Confidential Patient Information

6231 66th Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F – (727) 544 3221

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?

anemia__	diabetes___	hepatitis__	pain swallowing__	stroke__
anxiety__	diarrhea__	hypertension__	prostate problem__	swollen ankles__
asthma___	ear aches__	immune problem__	osteo arthritis___	swollen joints__
bipolar__	emphysema__	kidney disease__	psoriasis__	thyroid problem__
bladder problem__	epilepsy___	liver disease__	rashes__	tingling__
bruise easily__	numbness__	lung problems__	rectal bleeding__	tuberculosis __
chronic fatigue__	gas problems__	melanoma__	rheumatoid arth. __	ulcers__
concussion __	gout__	ANY cancer___	short of breath__	vascular disease__
constipation__	headaches__	menstrual problem_	sinusitis__	visual problems__
depression__	heart disease__	migraines__	stomach pain__	vomiting__

____ **NONE OF THE ABOVE**

Are you or do you think you may be PREGNANT? No___ Yes___ IF YES, TELL THE DOCTOR!

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

Are you regularly taking **over the counter** medications? **___No ___Yes** **<u>Please circle</u>**: 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?**

ADHD__	Asthma__	Chronic Pain__	Epilepsy__	Kidney disease_
Allergy___	Birth control __	Clotting__	Estrogen___	Migraines__
Antibiotics__	Blood Pressure_	Depression__	Headaches__	Osteoporosis__
Anxiety__	Cancer__	Diabetes__	Heart Disease__	Progesterone__
Arthritis__	Cholesterol__	Diuretic__	Indigestion__	Testosterone__

Please <u>list</u> names and dosage of medications: ______
____

Do you have a **PACEMAKER IMPLANTED**? ___Yes When? ________________

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? ____

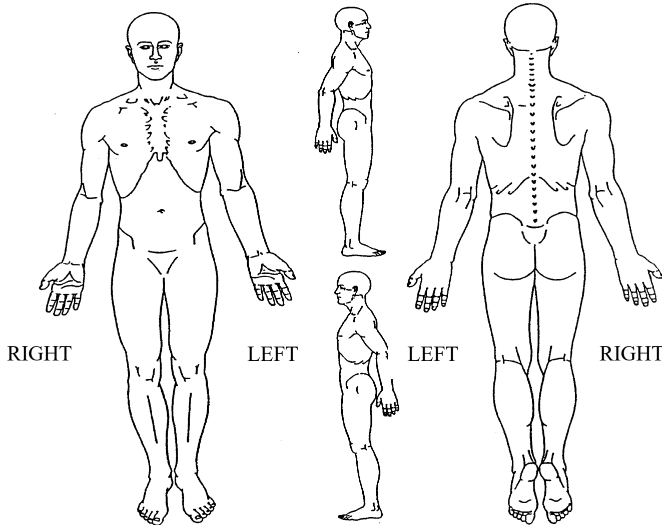
List any PREVIOUS **car** or **work accident / injury**? __**No** __**Yes…** If yes, give **date** and briefly describe:
____
____
____

Are you? __Single __Married __Separated __Divorced __Widowed
Highest level of education: ___ Grade ___ GED ___ High School Graduate ___? Years of college
Are you a **student now**? ___ 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: Ache, 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 perform due to your injuries:

___Walking	___Sexual Activity	___Writing	___Carrying
___Standing	___Dizziness	___Grasping	___Pushing
___Sitting	___Hearing	___Holding	___Pulling
___Driving	___Seeing	___Pinching	___Reaching
___Lifting	___Reading	___Leaning	___Reclining
___Restful Sleeping	___Tasting	___Stooping	___Riding in car
___Talking	___Smelling	___Squatting	___Plane travel
___Eating	___Using the phone	___Climbing	___Sports
___Bathing	___Grooming	___Kneeling	___Exercising
___Showering	___Dressing	___Bending	___Work activities
___Using the toilet	___Typing	___Twisting	

Other ____

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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___

Did the Hospital send you to any other doctor? YES___ NO___ Who? _________________________________

Did the Hospital tell you to follow up your primary care doctor? YES___ NO___

Have you been examined by any other physician since the accident? YES___ NO___ Who? _______________

What treatments have you received? ____

____

____

One of our Doctors will review this information with you. Please make sure you talk to him/her about any questions you may have regarding your health history.