

NEW ADULT PATIENT HISTORY INTAKE

To our new patients: *Welcome* to the practice of Jonathan E. Fenton, D.O.
To help us establish you with our practice, please provide us with your complete health history.

Today's Date: _____

Personal History

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

Occupation _____ Birthplace _____

Your Primary Doctor: _____ Referred by: _____

ALLERGIES:

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____

Additional problems or concerns you would like addressed:

*Note: we may not be able to address every problem during the course of one visit.

Current Medications	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Herbs / Vitamins/ Supplements

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

Name:

List prior hospitalizations, surgeries, & major injuries:

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother
Alcoholism / Drug Abuse					
Alzheimer's					
Elevated Cholesterol					
Arthritis					
Asthma					
Bleeding Disorder					
Breast Cancer					
Prostate Cancer					
Colon Cancer					
COPD / Emphysema					
Depression					
Diabetes					
Epilepsy					
Glaucoma					
Heart Attack					
Heart Disease					
High Blood Pressure					
Irritable Bowel Syndrome					
Kidney Disease					
Liver Disease / Hepatitis					
Mental Illness					
Migraine Headaches					
Pneumonia					
Other Cancer-Type?					
Stroke					
Suicide					
Thyroid disease					
Other					

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SOCIAL HISTORY (check those that apply):

Patient Name: _____

Marital status:	Education level completed:	Quality of Diet
<input type="checkbox"/> Single	<input type="checkbox"/> high school	<input type="checkbox"/> Excellent
<input type="checkbox"/> Married	<input type="checkbox"/> college	<input type="checkbox"/> Good
<input type="checkbox"/> Divorced	<input type="checkbox"/> professional school	<input type="checkbox"/> Fair
<input type="checkbox"/> Widowed	<input type="checkbox"/> other: _____	<input type="checkbox"/> Need Help!

Living arrangement:
 Alone family roommate significant other
 Children (list sex/ages): _____

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, # _____ yrs. # _____ packs per day
Did you ever smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when did you quit? _____
Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much? Type _____ & _____ drinks per week
Do you drink caffeinated beverages?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, type / how much? _____
Do you exercise regularly?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you enjoy your job?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you allow time to unwind and relax?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you sleep soundly?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____

REVIEW OF SYSTEMS

Patient Name: _____

Check any symptoms that currently apply to you:

Constitutional

- poor appetite
- fevers
- chills
- food craving
- weight loss
- weight gain
- fatigue

Eyes

- eye pain
- blurred vision
- excess tearing
- poor vision ___ night

Ears,Nose,Mouth,Throat

- ringing ears
- nosebleeds
- postnasal drip
- sinus problems
- trouble with taste/smell
- poor hearing
- earaches

Immune System

- too many infections
- allergies to food
- allergies to environment
- other concerns

Blood System

- lymph gland swelling
- anemia
- easy bruising

Ears,Nose, Mouth, Throat

- headaches
- jaw clicks
- teeth problems
- grinding teeth
- trouble chewing
- facial pain
- sore throat
- mouth sores
- bad breath

Heart & Circulation

- chest pain
- lightheadedness
- fainting
- swelling feet
- blood clots
- varicose veins

Breathing & Lungs

- shortness of breath
- wheezing or asthma
- repeated colds/flu
- cough dry/irritating

Sexual Organs

- infertility
- pain with sex
- erection problems
- poor sexual response
- repeated infections

Muscles,Bones & Joints

- neck pain
- back pain
- sciatica
- painful joints:**
- shoulder ___ elbow
- hip ___ knee ___ ankle
- wrist ___ fingers
- joint swelling
- muscle weakness
- muscle cramps

Skin, Hair ,Breast

- breast lumps or pain
- itching, hives
- hair loss
- dry skin, eczema

Nerves,Movement, Brain

- seizures
- nerve pain
- poor balance
- poor coordination
- tremors or shaking

Women

- pelvic pain
- hot flashes
- painful periods
- premenstrual syndrome

Digestion & Intestine

- indigestion
- belching
- difficulty swallowing
- heartburn
- nausea
- liver trouble
- vomiting
- diarrhea
- cramping bowels
- gassy gut
- constipation
- abdominal pain
- blood in stool

Urine, Kidney, Bladder

- painful urination
- wake up to urinate
- kidney stones
- loss of control
- frequent urination
- sudden urge
- blood/pus urine

Female Reproductive

- age period started
- # of pregnancies
- # live births
- # children living
- past infertility

IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.

YOUR PRIMARY CARE DOCTOR'S NAME _____

YOUR PRIMARY CARE DOCTOR'S ADDRESS _____

DO YOU WANT A COPY OF THE REPORT SENT TO YOUR PRIMARY DOCTOR? _____

This history record has been designed to facilitate our patients' continuity of care. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

Date Patient / Guardian signature

Date

Physician Signature

Date

JONATHAN E. FENTON, D.O., F.A.A.P.M.&R.

Board Certified by:
A.A.P.M.& R.
A.O.C.P.M.& R.
AAO Neuro Musculoskeletal Medicine
& Osteopathic Manipulation

Practice limited to:
Physical & Orthopedic Medicine
Osteopathic Diagnosis & Treatment
Diagnostic Musculoskeletal Ultrasound
Image Guided Spinal & Joint Injections

Patient Information Consent Form

I have read and fully understand Dr. Jonathan Fenton's Notice of Information Practices. I understand that Dr. Fenton may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Dr. Fenton will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Dr. Fenton's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

321 Main Street, Suite C, Winooski, VT 05404
(802) 859-0000 Fax (802) 859-0005
www.JFentonDO.medem.com

PATIENT INFORMATION

Patient Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____ Sex: M / F

Age _____ Date of Birth _____

Married ___ Single ___ Partnered ___ Emergency Contact _____

Reason for Visit _____ Date of Injury _____

Primary Doctor _____ Phone Number _____

Referring Doctor _____ Phone Number _____

INSURANCE INFORMATION

Insurance Company _____

Guarantor _____

Financial Policy:

You, the patient are responsible for your medical bills. If it is an insurance which we bill we will submit the forms for you and bill you for any unpaid balance. If it is one we do not bill we will give you a form which you can submit yourself. Not all insurances will cover office visits. Contact your insurance carrier with coverage questions. You will be billed for missed appointments without 24 hours notice.

Managed Care Patients Please Note

All patients are responsible for obtaining and keeping track of referrals from their primary doctors. A referral **must be complete and at our office before** the actual office visit. Failure to have the referral at this office will result in the patient being responsible for payment in full.

Co-pays are due at time of service

Patients are ultimately responsible for all payments

I authorize the release of any information necessary to process my claims

Signed _____ Date _____