# R2 MEDICAL CENTERS

2072-B East Commercial Ave Lowell, IN 46356 / Phone: 219-696-8916 / rmedcentersnwi.com

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**WELCOME TO R2 MEDICAL CENTERS!** Today's date: _____/_____/_____

To begin, how did you hear about our office? _____

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**PATIENT INFORMATION:**

Patient name: _____ Date of Birth: _____/_____/_____ ☐ Male ☐ Female

SS#/SIN: _____-_____-_____ Email address: _____

Home phone number: (_____) _____-_____ Cell phone number: (_____) _____-_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patients address - Street: _____ City: _____ State: _____ Zip: _____

Spouse/Patent/Guardian's name: _____

Emergency contact name: _____ Phone number: (_____) _____-_____

Emergency contact relationship to patient: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

**In case of medical emergency, if the patient is of school age 15+, it is okay to treat in my absence.*

Parent or guardian signature: _____ Date: _____/_____/_____

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**RESPONSIBLE PARTY:**

☐ *Check if the patient is the responsible party (If so, you are not required to fill out this section)*

Name of responsible party: _____ Relationship to patient: _____

Party's address - Street: _____ City: _____ State: _____ Zip: _____

Home phone number: (_____) _____-_____ Cell phone number: (_____) _____-_____

Date of Birth: _____/_____/_____ Is the responsible party currently a patient? ☐ Yes ☐ No

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**INSURANCE HOLDER:**

*Do you have insurance?* ☐ *YES* ☐ *NO (If NO, then you are not required to fill out this section)*

Name of insured: _____ Relationship to patient: _____

Date of Birth: _____/_____/_____ SS#/SIN: _____-_____-_____ INS ID number: _____

Employer: _____ Union Number: _____ Insurance company: _____

Employer address - Street: _____ City: _____ State: _____ Zip: _____

Insurance address - Street: _____ City: _____ State: _____ Zip: _____

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**HEALTH HISTORY:** Todays date: _____/_____/_____

Patient name: _____ Date of Birth: _____/_____/_____ Chief complaint: _____

**HISTORY OF PRESENT ILLNESS:**

Location: _____ Quality: _____ Severity: _____
(Where is the pain/problem located?) (Example: Normal vs abnormal color, activity, etc.) (Pain on scale 1-10, 10 being most severe)

Duration: _____ Timing: _____ Context: _____
(How long have you had this pain, when did it begin?) (Does the pain/problem occur at a certain time?) (Where were you at the onset of this pain/problem?)

Associated signs/symptoms: _____
(What other associated problems have you been having?)

Modifying factors: _____
(What makes the pain/problem worse or better? Have you had precious episodes?)

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**PAST MEDICAL HISTORY:**

Have you ever had the following (CIRCLE "YES" or "NO" or leave blank if you are uncertain)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Measles | YES | NO | Anemia | YES | NO | Back Trouble | YES | NO |
| Mumps | YES | NO | Bladder Infection | YES | NO | High Blood Pressure | YES | NO |
| Chicken Pox | YES | NO | Epilepsy | YES | NO | Low Blood Pressure | YES | NO |
| Whooping Cough | YES | NO | Migraines | YES | NO | Hemorrhoids | YES | NO |
| Scarlet Fever | YES | NO | Tuberculosis | YES | NO | Asthma | YES | NO |
| Diphtheria | YES | NO | Diabetes | YES | NO | Hives of Eczema | YES | NO |
| Small Pox | YES | NO | Cancer | YES | NO | AIDS or HIV | YES | NO |
| Pneumonia | YES | NO | Polio | YES | NO | Infectious Mono | YES | NO |
| Rheumatic Fever | YES | NO | Glaucoma | YES | NO | Bronchitis | YES | NO |
| Arthritis | YES | NO | Hernia | YES | NO | Mitral Valve Prolapse | YES | NO |
| Venereal Disease | YES | NO | Blood Transfusion | YES | NO | Stroke | YES | NO |
| Hepatitis | YES | NO | Plasma Transfusion | YES | NO | Date of last chest x-ray: | __/ | __ |
| Ulcer | YES | NO | Kidney Disease | YES | NO | Thyroid Disease | YES | NO |
| Bleeding Tendency | YES | NO | Any Other Diseases | YES | NO | _____ | | |

**Previous Hospitalizations/Surgeries/Serious Illnesses:**

_____ When: _____ Hospital/City/State: _____

_____ When: _____ Hospital/City/State: _____

**MEDICATIONS:**

(LIST and be sure to include NON-Prescription)

_____

Have you ever taken Fen-Phen/Redux? YES, NO

Are you taking any medications for acid indigestion? YES NO
(Include prescription/over the counter) If YES, what type? _____

**ALLERGIES:**

(List ALL allergies/sensitivities to medications, food, and other items)

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

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**PATIENT SOCIAL HISTORY:** Today's date: _____/_____/_____

Patient name: _____ Date of Birth: _____/_____/_____

(Check next to all that applies)

Use of Alcohol: __ Never __ Rarely __ Moderate __Daily

Use of Tobacco: __ Never __ Rarely __ Moderate __Daily

Use of Drugs: __ Never __ Rarely __ Moderate __Daily Type: _____

**FAMILY MEDICAL HISTORY:**

| Relationship | Age | Disease (if applicable) | If Deceased, cause of death |
|---|---|---|---|
| Father: | _____ | _____ | _____ |
| Mother: | _____ | _____ | _____ |
| Siblings: | _____ | _____ | _____ |
| Siblings: | _____ | _____ | _____ |
| Siblings: | _____ | _____ | _____ |
| Siblings: | _____ | _____ | _____ |
| Spouse: | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |

To the best of knowledge, the questions on this form have all been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

_____ Today's date: _____/_____/_____

Signature of the Patient, Parent, or Guardian

_____ Today's date: _____/_____/_____

Signature of the Doctor