



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check which box applies to you (mark all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Decreased hearing  | <input type="checkbox"/> Varicose veins                  | <input type="checkbox"/> Chronic fatigue                |
| <input type="checkbox"/> Ringing in ear   | <input type="checkbox"/> Phlebitis                       | <input type="checkbox"/> Weight loss recent             |
| <input type="checkbox"/> Ear infections   | <input type="checkbox"/> Loss of appetite recent         | <input type="checkbox"/> Anemia                         |
| <input type="checkbox"/> Dizzy spells   | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Bruise easily                  |
| <input type="checkbox"/> Failing vision   | <input type="checkbox"/> Cataracts                       | <input type="checkbox"/> Difficulty swallowing          |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Thyroid disease                 | <input type="checkbox"/> Indigestion or heartburn       |
| <input type="checkbox"/> Eye infections   | <input type="checkbox"/> Persistent<br>nausea/vomiting   | <input type="checkbox"/> Doubled/blurred vision         |
| <input type="checkbox"/> Nose bleeds  | <input type="checkbox"/> Peptic ulcers                   | <input type="checkbox"/> Convulsions/Seizures           |
| <input type="checkbox"/> Sinusitis  | <input type="checkbox"/> Abdominal pains                 | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Sore throat recent   | <input type="checkbox"/> Change in bowel                 | <input type="checkbox"/> Tremor/Hand shaking            |
| <input type="checkbox"/> Hay fever  | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Numbness/Tingling<br>sensation |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> Headaches frequent             |
| <input type="checkbox"/> Hoarseness   | <input type="checkbox"/> Diverticulosis                  | <input type="checkbox"/> Arthritis                      |
| <input type="checkbox"/> Pneumonia/Pleurisy   | <input type="checkbox"/> Blood in stool                  | <input type="checkbox"/> Gout                           |
| <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Hemorrhoids                     | <input type="checkbox"/> Back pain current              |
| <input type="checkbox"/> Asthma/Wheezing  | <input type="checkbox"/> Gall bladder trouble            | <input type="checkbox"/> Bone fracture                  |
| <input type="checkbox"/> Shortness of breath:<br><input type="checkbox"/> on exertion | <input type="checkbox"/> Jaundice                        | <input type="checkbox"/> Foot pain                      |
| <input type="checkbox"/> laying flat  | <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Cold/Numb feet                 |
| <input type="checkbox"/> Chest pain   | <input type="checkbox"/> Urine infections                | <input type="checkbox"/> Rashes                         |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Painful urination               | <input type="checkbox"/> Hives                          |
| <input type="checkbox"/> Heart murmur   | <input type="checkbox"/> Blood in urine                  | <input type="checkbox"/> Psoriasis                      |
| <input type="checkbox"/> Palpitations   | <input type="checkbox"/> Control of urination            | <input type="checkbox"/> Eczema                         |
| <input type="checkbox"/> Irregular pulse  | <input type="checkbox"/> Decreased force in<br>urination | <input type="checkbox"/> Sleeping difficulties          |
| <input type="checkbox"/> Fainting spells  | <input type="checkbox"/> Kidney stones                   | <input type="checkbox"/> Nervousness                    |
| <input type="checkbox"/> Swollen ankles   | <input type="checkbox"/> Venereal disease                | <input type="checkbox"/> Memory loss                    |
| <input type="checkbox"/> Mental illness   | <input type="checkbox"/> Recent hair loss                | <input type="checkbox"/> Depression                     |
| <input type="checkbox"/> Rheumatic  | <input type="checkbox"/> Moodiness                       | <input type="checkbox"/> Phobias                        |
| <input type="checkbox"/> Herpes   | <input type="checkbox"/> Scarlet fever                   | <input type="checkbox"/> TB                             |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Chicken pox                     | <input type="checkbox"/> Measles                        |
| <input type="checkbox"/> Leg pain when walking  |  |   |

- Smoking \_\_\_\_\_ per day \_\_\_\_\_ # of years
- Alcohol \_\_\_\_\_ per week
- Coffee/Tea \_\_\_\_\_ cups per day

IMMUNIZATIONS (YEAR OF LAST INJECTION):

\_\_\_\_\_ Pneumonia                      \_\_\_\_\_ Flu                      \_\_\_\_\_ Tetanus  
\_\_\_\_\_ Diphtheria                      \_\_\_\_\_ Measles                      \_\_\_\_\_ Mumps  
\_\_\_\_\_ Rubella                      \_\_\_\_\_ Polio                      \_\_\_\_\_ Hepatitis

FEMALES: Menstrual history

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Regular   | <input type="checkbox"/> Pain/Cramps with menstrual flow |
| <input type="checkbox"/> Irregular | <input type="checkbox"/> Flushing/Menopause              |

Date of last pap test \_\_\_\_\_ Date of last Mammogram \_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ # of miscarriages \_\_\_\_\_

Birth control method \_\_\_\_\_

# WELCOME TO THE BEALS INSTITUTE

## AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Dr. \_\_\_\_\_ to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.

## ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of surgical/medical benefits to Dr. \_\_\_\_\_ for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information given by me on the pages below is current and correct. I request that payment of authorized benefits be made on my behalf. I have reviewed and agree with the Beals Institute privacy practices.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT HISTORY:

Please list current problems:

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

Please list medications:

Medication	Dosage	How Taken

Please list medication allergies:

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