RONALD H. JOHNSON, M.D.

PATIENT INFORMATION SHEET

Patient name _____ Birthdate _____
Address _____ Age _____
City/state/zip _____ Home phone _____
Occupation _____ Work phone _____
E-mail address _____ Social Security# _____
Marital status ___ Single ___ Married ___ Other

Primary care physician (name) _____
Who can we contract in case of an emergency? (name/phone) _____

How did you hear about this office? _____

PATIENT POLICY

Payment is due in full at the time of service ($165 initial - $55 followup). We do not process insurance claims out of the office and therefore insurance cards are not accepted at the time of your visit. We do accept cash, personal checks, or credit card (Mastercard/Visa).
There is a $40 charge for all returned checks. A receipt will be given (if requested) at the time of payment so that you can send it in to your insurance company on your own to request reimbursement.

I understand the above payment policy and agree to it.
Signature _____ Date _____

If you wish to pay your account with credit card, please complete the following:
Account number _____ Type of card _____ Exp date _____

RECORDS RELEASE

I hereby authorize Dr. Ronald H. Johnson to release any of my medical information to my referring doctor as necessary, to my insurance company as necessary, and to the responsible party as needed and as requested.

Signature _____ Date _____

RONALD H. JOHNSON, M.D.
PATIENT MEDICAL HISTORY

(Please check any of the following symptoms that you currently have to any significant degree and check any of the following conditions you may have had in the past)

Alcoholism _____
Anemia _____
Asthma _____
Anorexia _____
Arthritis _____
Appendicitis _____
Bleeding disorder _____
Blood clots _____
Back pain (severe) _____
Breast lump _____
Bulimia _____
Blurred vision _____
Bloating/gas _____
Bowel disease _____
Balance problems _____
Cancer _____
Cataracts _____
Chemical dependency ___
Constipation (chronic) ___
Chest pain _____
Change in vision _____
Circulation problems ____
Cholesterol problem ____
Cough (persistent) _____
Depression _____
Diarrhea _____
Diabetes _____
Dizziness/fainting spells ___
Drug Abuse _____
Eczema _____
Emphysema _____
Epilepsy (seizure) _____
Erection difficultites ____

Fatigue (chronic) _____
Fibromyalgia _____
Glaucoma _____
Goiter _____
Gallstones _____
Gout _____
Hives/rashes _____
Hay fever _____
HIV positive _____
Herpes _____
Hepatitis _____
Headaches (frequent) _____
Hearing loss _____
Heart murmur _____
Heartburn/indigestion _____
High blood pressure _____
Heart disease _____
Hemorrhoids _____
Hot flashes _____
Irritible bowel _____
Heartbeat - rapid/irregular _____
Kidney stones _____
Lupus _____
Leg/ankle swelling _____
Liver Disease _____
Memory problems _____
Multiple sclerosis _____
Migraines _____
Menstrual irregularities _____
Nausea (chronic) _____
Nervousness _____
Numbness/tingling _____
Nervous breakdown _____

Osteoporosis _____
Pap smear abnormal _____
Pacemaker _____
Polio _____
Prostate problems _____
Psychiatric illness _____
Pulmonary embolism ____
Psoriasis _____
Rheumatic fever _____
Rectal bleeding _____
Steroid use _____
Skin lesion changes _____
Sickle Cell _____
Sinuses (chronic) ____
Swallowing problem ____
Sweating - abnormal ____
Sleep disturbance _____
Suicide attempt _____
Stroke/TIA _____
Shortness of breath _____
Sexual transmitted Dz _____
Tremor (shaking) _____
Tuberculosis _____
Thyroid (underactive) ____
Thyroid (overactive) ____
Thirst excess _____
Tinnitus (ear ringing) ____
Ulcers _____
Urine - blood _____
Urination excess _____
Urine incontinence _____
Vision changes _____
Varicose veins _____

MEDICATION ALLERGIES: ___ No ___ Yes (list) _____

CURRENT MEDICATIONS (include over the counter): _____

_____

_____

PATIENT NAME: _____ _____

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WEIGHT LOSS HISTORY

TELL ME ABOUT YOUR WEIGHT HISTORY (length of time overweight, specific reasons?, etc.) _____

_____

EVER BEEN ON MEDICATIONS FOR WEIGHT LOSS? No / Yes - explain _____

_____

PREVIOUS WEIGHT LOSS PROGRAMS WHEN? HOW LONG? SUCCESSFUL?

_____

_____

_____

PREGNANCY HISTORY

NUMBER OF PREGNANCIES _____ # live children _____

CURRENT CONTRACEPTION _____

SURGICAL/HOSPITAL HISTORY

MAJOR SURGERIES OR OPERATIONS: _____ No _____ Yes

If so, list type of operation and approximate age at timeof operation: _____

_____

HOSPITALIZATIONS (other than for surgery) _____ No _____ Yes

If so, list reason and age at the time of hospitalization: _____

_____

SOCIAL HISTORY

SMOKE: _____ Never

_____ Not now, but yes in the past - How much? and when quit? _____

_____ Yes, currently - How much and for how long? _____

ALCOHOL: _____ No _____ Yes - How much (frequency)? _____

CAFFEINE: _____ No _____ Yes - What kind and how much? _____

OTHER ILLICIT DRUG USE: _____

FAMILY HISTORY (PLEASE CHECK IF ANYONE IN THE IMMEDIATE FAMILY HAS HAD OR CURRENTLY HAS ANY OF THE FOLLOWING CONDITIONS)

____ CANCER	____ DIABETES	____ HIGH BLOOD PRESSURE
____ STROKE	____ SEIZURES	____ HEART PROBLEMS
____ MENTAL PROBLEMS	____ THYROID PROBLEMS	____ KIDNEY DISEASE
____ LIVER DISEASE	____ LUNG DISEASE	____ CHEMICAL DEPENDENCY
____ ARTHRITIS	____ OTHER (list)	

PATIENT NAME: _____

LAB WORK (TSH)

All patients are required to have a blood test, **Thyroid Stimulating Hormone (TSH),** performed as a part of their medical work up. Patients who have had this test performed within the past ninety (90) days by their Primary Care Physician may submit this lab work to our office. Patients who have not had this test performed may do so at the lab on campus for a nominal charge. This test must be performed as a part of your medical treatment. Failure to have this test performed will prevent further medication from being dispensed.

I have read and understand that my medication will be discontinued if I fail to provide the necessary lab work, **TSH.**

_____

Patient Signature

_____

Date