

# TLC HealthCare™ Companies

## Patient History Form

Note: This is a confidential record and will be kept in the TLC administrative office. Information contained here will not be released to anyone without your authorization to do so.

**TODAY'S DATE** \_\_\_/\_\_\_/\_\_\_      **DATE OF ADMISSION TO FACILITY** \_\_\_/\_\_\_/\_\_\_  
**LAST NAME** \_\_\_\_\_      **FIRST NAME** \_\_\_\_\_  
**SOCIAL SECURITY NUMBER** \_\_\_\_\_      **DATE OF BIRTH** \_\_\_/\_\_\_/\_\_\_      **AGE** \_\_\_  
**ADDRESS** \_\_\_\_\_      **NAME OF FACILITY** \_\_\_\_\_  
**PHONE NUMBER ( )** \_\_\_\_\_      **FAX NUMBER ( )** \_\_\_\_\_  
**RESPONSIBLE PARTY** \_\_\_\_\_      **ADDRESS** \_\_\_\_\_  
**PHONE NUMBER ( )** \_\_\_\_\_      **ALT PHONE NUMBER ( )** \_\_\_\_\_  
**OCCUPATION** \_\_\_\_\_      **MARITAL STATUS** Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_  
**INSURANCE CARRIER** \_\_\_\_\_      **POLICY #** \_\_\_\_\_      **GRP #** \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_      **PHONE NUMBER** \_\_\_\_\_  
**2ND INSURANCE** \_\_\_\_\_      **POLICY #** \_\_\_\_\_      **GRP #** \_\_\_\_\_

### **Advance Directives**

Medical Power of Attorney \_\_\_\_\_ Phone # \_\_\_\_\_  
Financial Power of Attorney \_\_\_\_\_ Phone # \_\_\_\_\_  
Living Will? Yes \_\_\_ No \_\_\_  
Code Status Full Code \_\_\_ Do Not Resuscitate (DNR) \_\_\_

### **List any PERSONAL PAST ILLNESS and/or SURGERIES and when they occurred.**

<u>Illness or Surgery</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Food Allergies \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Are you on a special diet? Yes \_\_\_ No \_\_\_ (If Yes, please explain)  
\_\_\_\_\_

**FEMALE** Postmenopausal Yes \_\_\_ No \_\_\_      Last Mammogram \_\_\_\_\_ Last PAP \_\_\_\_\_

**MALE** Last PSA or Prostate Exam \_\_\_\_\_

Last Eye Exam \_\_\_\_\_      Colon Cancer Screen? Yes \_\_\_ No \_\_\_

Substance Abuse? Yes \_\_\_ No \_\_\_      Do you Smoke? Ever? Yes \_\_\_ No \_\_\_

Do you drink? Ever? Yes \_\_\_ No \_\_\_      If Yes, how much? \_\_\_\_\_

Tattoo's? Yes \_\_\_ No \_\_\_

**IMMUNIZATIONS:** Flu \_\_\_/\_\_\_/\_\_\_      Pneu \_\_\_/\_\_\_/\_\_\_      Tetanus \_\_\_/\_\_\_/\_\_\_      Other \_\_\_/\_\_\_/\_\_\_

Patient or Representative Signature \_\_\_\_\_      Date \_\_\_/\_\_\_/\_\_\_



Patient or Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### REVIEW OF SYSTEMS

Indicate if you have or have had any problems related to the following systems.

**Constitutional Symptoms**

Fever	Y	N
Chills	Y	N
Abnormal Weight Loss	Y	N
Other _____		

**Integumentary**

Skin Rash	Y	N
Easy Bruising	Y	N
Nail Problems	Y	N
Other _____		

**Eyes**

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other _____		

**Musculoskeletal**

Joint Pain	Y	N
Joint Swelling	Y	N
Back Pain	Y	N
Other _____		

**Allergic/Immunologic**

Hay Fever	Y	N
Sinus Problems	Y	N
Other _____		

**Ear/Nose/Throat/Mouth**

Ear Pain	Y	N
Nasal Obstruction	Y	N
Sore Throat	Y	N
Other _____		

**Neurological**

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other _____		

**Genitourinary**

Urine Incontinence	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other _____		

**Endocrine**

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

**Respiratory**

Wheezing	Y	N
Frequent Cough	Y	N
Sputum	Y	N
Other _____		

**Gastrointestinal**

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

**Hematologic/Lymphatic**

Swollen Nodes	Y	N
Excessive Bleeding	Y	N
Other _____		

**Cardiovascular**

Chest Pain on Exertion	Y	N
Shortness of Breath on Exertion	Y	N
Calf Pain on Exertion	Y	N
Other _____		

**Psychologic**

Do you feel sad	Y	N
Loss of interest in activities	Y	N
Loss of energy	Y	N
Thoughts of suicide	Y	N
Other _____		

**Male**

Penile Discharge	Y	N
Testicular Pain	Y	N
Penile Lesions	Y	N
Other _____		

**Female**

Vaginal Discharge	Y	N
Heavy Flow	Y	N
Other _____		

Do you use assistive devices? Cane \_ Walker \_ Wheelchair \_ Other \_\_\_\_\_

Patient or Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

1/6/09