

Jack C. Nichols II, M.D.

1230 East Street, Suite 1 Redding, California 96001
NORTH VALLEY ORTHOPAEDIC MEDICAL GROUP, INC.
530-246-2430

Patient History Sheet

NAME: _____ **DATE:** _____

Height: _____ ft. _____ in. Weight: _____ lbs. Age: _____ yrs.

PAST MEDICAL HISTORY

Who is your regular family doctor or internist who follows your general medical problems? _____

Do you have any allergies? _____

Do you take any prescription medicine? (Please include dosages and when taken) _____

Other medicine? (i.e. over the counter, herbals, etc.) _____

Are all immunizations up to date? Yes No → Which are due? _____

SOCIAL HISTORY

Marital Status: Married Separated Divorced Widowed Single

Children? No Yes How Many? _____ Live alone? No Yes

Employment: Employed Work in home Retired Student Daycare
(occupation: _____)

Exercise routine: Daily Weekly Monthly Rarely Never

Type of exercise activity: _____

Do you currently smoke? No Yes → # of packs _____ # of years _____

Did you smoke previously? No Yes → # of packs _____ # of years _____ how long ago? _____ yrs.

Do you drink alcohol? No Yes → 1-2x/week 1-2x/month 1-2x/year

Any history of substance abuse? No Yes → What? _____

ILLNESSES

Do you have any serious medical illnesses? (Please check the appropriate box)

- Diabetes High Blood Pressure Heart Trouble Ulcer Disease
- Emphysema Seizures or Epilepsy HIV/ AIDS Asthma
- Cancer Hepatitis Other → _____

OPERATIONS

Have you had any operations? (Please list in order of most recent.)

TYPE	DATE	TYPE	DATE
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any serious injury or accident? No Yes → Details/dates: _____

Jack C. Nichols II, M.D.

1230 East Street, Suite 1 Redding, California 96001
 NORTH VALLEY ORTHOPAEDIC MEDICAL GROUP, INC.
530-246-2430

Patient History Sheet pg.2

Name: _____

Date: _____

REVIEW OF SYSTEMS

Please check any medical problems that you have had, or been told you had, past or present.
 Give dates if appropriate.

NEUROLOGICAL:	DATE	EARS, NOSE, & THROAT	DATE	HEART & BLOOD VESSELS	DATE
<input type="checkbox"/> Seizures or Epilepsy		<input type="checkbox"/> Ear aches		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Fainting Spells		<input type="checkbox"/> Deafness		<input type="checkbox"/> Shortness of breath	
<input type="checkbox"/> Headaches		<input type="checkbox"/> Wear hearing aid		<input type="checkbox"/> Heart murmur/palpitations	
<input type="checkbox"/> Disorder of Brain		<input type="checkbox"/> Sinus infections		<input type="checkbox"/> Heart attack	
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Nose bleeds		<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Neuritis		<input type="checkbox"/> Deviated septum		<input type="checkbox"/> AIDS or related condition	
<input type="checkbox"/> Paralysis		<input type="checkbox"/> Wear dentures		<input type="checkbox"/> Pain/pressure in chest	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Hay fever/Allergies		<input type="checkbox"/> Anemia	
GASTROINTESTINAL:		EYES:		<input type="checkbox"/> Blood clots	
<input type="checkbox"/> Ulcers		<input type="checkbox"/> Eye Injury		RESPIRATORY:	
<input type="checkbox"/> Indigestion		<input type="checkbox"/> Dilated Pupil		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Hiatal Hernia		<input type="checkbox"/> Blindness		<input type="checkbox"/> Shortness of breath	
<input type="checkbox"/> Jaundice		<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Bronchitis	
<input type="checkbox"/> Colitis		<input type="checkbox"/> Cataracts		<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Wear Glasses		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Gallbladder disease		URINARY TRACT:		ENDOCRINE:	
<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Difficulty urinating		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Intestinal bleeding		<input type="checkbox"/> Bladder infection		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Abdominal bleeding		<input type="checkbox"/> Kidney stones		<input type="checkbox"/> Adrenal disease	
		<input type="checkbox"/> Prostate cancer			

FAMILY HISTORY

FATHER	MOTHER	BROTHER/SISTER	BROTHER/SISTER	BROTHER/SISTER
<input type="checkbox"/> Living →Age: _____	<input type="checkbox"/> Living →Age: _____	<input type="checkbox"/> Living →Age: _____	<input type="checkbox"/> Living →Age: _____	<input type="checkbox"/> Living →Age: _____
<input type="checkbox"/> Deceased	<input type="checkbox"/> Deceased	<input type="checkbox"/> Deceased	<input type="checkbox"/> Deceased	<input type="checkbox"/> Deceased
Cause of death: _____	Cause of death: _____	Cause of death: _____	Cause of death: _____	Cause of death: _____
PRESENT HEALTH	PRESENT HEALTH	PRESENT HEALTH	PRESENT HEALTH	PRESENT HEALTH
<input type="checkbox"/> Excellent <input type="checkbox"/> Fair	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair
<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor
HAS HE HAD ANY OF THE FOLLOWING?	HAS SHE HAD ANY OF THE FOLLOWING?	HAS SHE/HE HAD ANY OF THE FOLLOWING?	HAS SHE/HE HAD ANY OF THE FOLLOWING?	HAS SHE/HE HAD ANY OF THE FOLLOWING?
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Nervous/Mental Disorder	<input type="checkbox"/> Nervous/Mental Disorder	<input type="checkbox"/> Nervous/Mental Disorder	<input type="checkbox"/> Nervous/Mental Disorder	<input type="checkbox"/> Nervous/Mental Disorder
<input type="checkbox"/> Other →	<input type="checkbox"/> Other →	<input type="checkbox"/> Other →	<input type="checkbox"/> Other →	<input type="checkbox"/> Other →

IMPORTANT!
PLEASE SIGN: _____

(Responsible party)

DATE _____ / _____ / _____

PHYSICIAN SIGNATURE: _____

DATE: _____ / _____ / _____

Jack C. Nichols II, M.D.

1230 East Street, Suite 1 Redding, California 96001
NORTH VALLEY ORTHOPAEDIC MEDICAL GROUP, INC.
530-246-2430

Patient Information Sheet

PATIENT NAME: _____ **DATE:** _____

Birth date: ____/____/____ Age: ____ yrs. Sex: M F Patient's SS#: ____/____/____

If patient is a minor, name of responsible parent or guardian: _____

Home address: _____ Mailing address: _____

City/State/ZIP: _____ Home phone: _____

Employer: _____ Occupation: _____
(If patient is a minor, responsible party's employer)

Bus. Address: _____ Bus. Phone: _____

Name of spouse: _____ Birth date: ____/____/____

Spouse's employer: _____ Occupation: _____
(If patient is a minor, 2nd responsible party's employer)

Bus. Address: _____ Bus. Phone: _____

Emergency contact: _____ Relationship: _____
(Name of nearest relative or friend not living with you)

Address: _____ Phone: _____

Patient was referred by: _____ Was the injury on the job? Y N

Please check the method of payment for today's professional services: Cash Check Visa M/C
FEEES ARE PAYABLE AND DUE AT THE TIME OF SERVICE

As participating providers, we will bill Medicare and any insurance companies we contract with.

If you do not have a card, please provide the information requested in the box.

Insurance Co.:	_____
Claim address:	_____
Group #:	_____ SS# ____/____/____
Insured name:	_____ DOB: ____/____/____

LIFETIME AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the doctor(s) whose name(s) appears above to furnish my insurance company(s), attorney, or legal representative any information which said parties may request concerning my present illness or injury. I hereby assign to the doctor whose name appears above any money to which I am entitled for medical and/or surgical expense relative to the service reported herein, but not to exceed my indebtedness to said physician and surgeon. It is understood that any money received from the above-named parties over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment.

Consent for treatment: I hereby grant authority to the physician in charge of the care of the patient whose name appears on this form to examine the patient and perform or order procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

IMPORTANT!
PLEASE SIGN: _____ **DATE** ____/____/____
(Responsible party)