



An Affiliate of Baptist Health Care

CHIEF COMPLAINT FORM

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Send Note?

Referral Physician: \_\_\_\_\_ Town: \_\_\_\_\_ Y N

Primary Care Physician: \_\_\_\_\_ Town: \_\_\_\_\_ Y N

Coach/Trainer/Team Doctor: \_\_\_\_\_ School: \_\_\_\_\_ Y N

Body part being seen for: \_\_\_\_\_

Side of Body (circle): Right Left Body

Date Symptoms Began: \_\_\_\_\_ Was there an injury? Yes / No

Workers Comp? Yes / No

If "Yes", how did it happen?

\_\_\_\_\_

Current Symptoms (circle):

Pain Swelling Catching Locking Instability Numb/Tingling

Other: \_\_\_\_\_

If there are symptoms, where are they located? \_\_\_\_\_

Are your symptoms (circle): Improving Worsening Stable

Are your symptoms (circle): Mild Mild/Mod Moderate Mod/Severe Severe

List activities or body positions making your symptoms worse (ex. walking, running, reaching overhead):

\_\_\_\_\_

List any prior treatment(s) for this complaint (ex. injections, surgery, physical therapy, ice):

\_\_\_\_\_

1. **ALLERGIES:** Please list any **allergies** and reactions to medications/substances in the PAST: or (circle) NONE

MEDICATION	REACTION	MEDICATION	REACTION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

2. **PHARMACY:** Name: \_\_\_\_\_ Location: \_\_\_\_\_

3. **MEDICATIONS:** Please list any **medication** you are currently taking:

MEDICATION	DOSE/FREQ	MEDICATION	DOSE/FREQ
1)		9)	
2)		10)	
3)		11)	
4)		12)	
5)		13)	
6)		14)	
7)		15)	
8)		16)	

4. **PAST MEDICAL HISTORY:** Check if you had any of these **medical problems** in the PAST: or (circle) NONE

ILLNESS	Y	ILLNESS	Y	ILLNESS	Y
Anemia		Heart Attack		Peripheral Vascular Disease	
Anxiety		Heart Failure		Psychiatric Illness: _____	
Asthma		Heart Murmur		Pulmonary Embolism	
Bleeding Problems		Hepatitis B		Reflux	
Blood Clot		Hepatitis C		Rheumatoid Arthritis	
Cancer: _____		High Blood Pressure		Sjogren's Disease	
Chest Pain/ Angina		HIV/AIDS		Skin Ulcer/ Breakdown	
COVID-19		Immune Deficiency		Sleep Apnea	
Deep Vein Thrombosis		Kidney Disease		Steroid Use	
Depression		Latex Allergy		Stroke	
Diabetes		Liver Disease		Thyroid Disease	
Gall Bladder Disease		Lupus		Tuberculosis- TB	
Gastric Ulcers		MRSA (resistant staph)		Urinary Infections	
Glaucoma		Neuropathy		Valve Disorders (heart)	
Gout		Osteoarthritis		Wound Healing Problem	
Heart Arrhythmia		Paralysis			

List any **other medical problems** NOT listed above:

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5. **PAST SURGICAL HISTORY:** Please list any **operations/surgeries** you had in the PAST: or (circle) NONE

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		7)	
2)		8)	
3)		9)	
4)		10)	
5)		11)	
6)		12)	

6. **PAST FAMILY HISTORY:** Please list major immediate **family medical problems:** or (circle) NONE

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

7. **SOCIAL HISTORY:** Please circle status use of the following:

Cigarette:            Never            Former            Current            Cigarettes per day: \_\_\_\_\_ Years: \_\_\_\_\_

Other tobacco:      Never            Former            Current            Type: \_\_\_\_\_ Years: \_\_\_\_\_

Alcohol:              Never            Former            Current            Drinks per day: \_\_\_\_\_ Type: \_\_\_\_\_

Illicit Drugs:        Never            Former            Current            Type: \_\_\_\_\_

**REVIEW OF SYSTEMS: Please mark any of the symptoms you are experiencing TODAY:**

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Chills  <input type="checkbox"/> Fever  <input type="checkbox"/> Fatigue  <input type="checkbox"/> Weight Loss  <input type="checkbox"/> Other: _____</p>	<p><b>SKIN</b></p> <p><input type="checkbox"/> Lesions  <input type="checkbox"/> Itching  <input type="checkbox"/> Rash  <input type="checkbox"/> Varicose Veins  <input type="checkbox"/> Skin color change  <input type="checkbox"/> Other: _____</p>	<p><b>NOSE</b></p> <p><input type="checkbox"/> Congestion  <input type="checkbox"/> Discharge  <input type="checkbox"/> Nose bleeds  <input type="checkbox"/> Sneezing  <input type="checkbox"/> Decreased sense of smell  <input type="checkbox"/> Other: _____</p>
<p><b>EYE</b></p> <p><input type="checkbox"/> Itching  <input type="checkbox"/> Pain  <input type="checkbox"/> Photophobia  <input type="checkbox"/> Vision Changes  <input type="checkbox"/> Dryness  <input type="checkbox"/> Other: _____</p>	<p><b>EAR</b></p> <p><input type="checkbox"/> Hearing Disturbance  <input type="checkbox"/> Hearing Loss  <input type="checkbox"/> Pain  <input type="checkbox"/> Tinnitus  <input type="checkbox"/> Other: _____</p>	<p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest Pain  <input type="checkbox"/> Lower extremity swelling  <input type="checkbox"/> Shortness breath lying down  <input type="checkbox"/> Palpitation  <input type="checkbox"/> Fainting  <input type="checkbox"/> Feels faint at times  <input type="checkbox"/> Irregular heart beat  <input type="checkbox"/> Other: _____</p>
<p><b>MOUTH/THROAT</b></p> <p><input type="checkbox"/> Difficulty Swallowing  <input type="checkbox"/> Hoarseness  <input type="checkbox"/> Lesions  <input type="checkbox"/> Dental Problems  <input type="checkbox"/> Sore Throat  <input type="checkbox"/> Voice Changes  <input type="checkbox"/> Dryness  <input type="checkbox"/> Other: _____</p>	<p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Cough  <input type="checkbox"/> Shortness of breath  <input type="checkbox"/> Coughing up blood  <input type="checkbox"/> Wheezing  <input type="checkbox"/> Shortness of breath at rest  <input type="checkbox"/> Sputum production  <input type="checkbox"/> Other: _____</p>	<p><b>GENITOURINARY</b></p> <p><input type="checkbox"/> Pain with urination  <input type="checkbox"/> Blood in urine  <input type="checkbox"/> Sexual dysfunction  <input type="checkbox"/> Urinary frequency  <input type="checkbox"/> Urinary hesitance  <input type="checkbox"/> Urinary inconstance  <input type="checkbox"/> Change in bladder habits  <input type="checkbox"/> Other: _____</p>
<p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Abdominal pain  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Nausea  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Change in bowel habits  <input type="checkbox"/> Heartburn  <input type="checkbox"/> Indigestion  <input type="checkbox"/> Stool inconstance  <input type="checkbox"/> Other: _____</p>	<p><b>NEURO</b></p> <p><input type="checkbox"/> Confusion/ memory loss  <input type="checkbox"/> Dizziness  <input type="checkbox"/> Headache  <input type="checkbox"/> Numbness  <input type="checkbox"/> Weakness  <input type="checkbox"/> Unsteadiness  <input type="checkbox"/> Change in speech  <input type="checkbox"/> Difficulty speaking  <input type="checkbox"/> Difficulty with ambulation  <input type="checkbox"/> Tingling  <input type="checkbox"/> Loss of balance  <input type="checkbox"/> Seizures  <input type="checkbox"/> Unusual sensation  <input type="checkbox"/> Other: _____</p>	<p><b>PSYCH</b></p> <p><input type="checkbox"/> Anxiety  <input type="checkbox"/> Depression  <input type="checkbox"/> Hallucinations  <input type="checkbox"/> Insomnia  <input type="checkbox"/> Mood problems  <input type="checkbox"/> Fearful  <input type="checkbox"/> Suicidal ideation  <input type="checkbox"/> Delusions  <input type="checkbox"/> Other: _____</p>
<p><b>MUSKULOSKELETAL</b></p> <p><input type="checkbox"/> Pain in joints  <input type="checkbox"/> Back pain  <input type="checkbox"/> Joint swelling  <input type="checkbox"/> Pain  <input type="checkbox"/> Stiffness  <input type="checkbox"/> Joint redness  <input type="checkbox"/> Muscle pain  <input type="checkbox"/> Joint Stiffness  <input type="checkbox"/> Muscle weakness</p>	<p><b>HEME/LYMPH</b></p> <p><input type="checkbox"/> Bleed/bruise easily  <input type="checkbox"/> Enlarged/tender lymph nodes  <input type="checkbox"/> Night sweats  <input type="checkbox"/> Abnormal bleeding  <input type="checkbox"/> Anemia  <input type="checkbox"/> Other: _____</p>	<p><b>ENDOCRINE</b></p> <p><input type="checkbox"/> Change in weight  <input type="checkbox"/> Cold/heat intolerance  <input type="checkbox"/> Hot flashes  <input type="checkbox"/> Excess thirst  <input type="checkbox"/> Excessive urination  <input type="checkbox"/> Appetite changes  <input type="checkbox"/> Other: _____</p>
		<p><b>GYNECOLOGICAL</b></p> <p><input type="checkbox"/> Change in menses  <input type="checkbox"/> Painful Intercourse  <input type="checkbox"/> Other: _____</p>

**Patient Registration Form**

Last Name:	First Name:	MI:
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Social Security: ____ - ____ - ____	Date of Birth: ____/____/____
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Additional gender category or other <input type="checkbox"/> Choose not to disclose. <input type="checkbox"/> Female-to-Male (FTM)/Transgender <input type="checkbox"/> Genderqueer, neither excl male or female <input type="checkbox"/> Male-to-Female (MTF)/Transgender	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Legally Sep <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Unknown <input type="checkbox"/> Married
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Address:	City:	State:	Zip:
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Email:

Primary Phone: (____) ____ - ____ <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone	Secondary Phone: (____) ____ - ____ <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone
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Preferred Language: \_\_\_\_\_

Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unknown/Decline to Answer	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Decline to Answer	U.S. Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawfully present in the U.S. <input type="checkbox"/> Not lawfully present in the U.S. <input type="checkbox"/> Decline to Answer
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**Responsible Party: This section refers to the person/party who should receive the bill**

Relationship to Patient:  Self (skip this section)  Parent  Spouse  Other

Last Name:	First Name:	MI:
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Social Security: ____ - ____ - ____	Date of Birth: ____/____/____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
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Address:	City:	State:	Zip:
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Primary Phone: (____) ____ - ____	Secondary Phone: (____) ____ - ____
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## Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant verbal discussions regarding my health care. By signing this form, I permit Baptist Medical Group ("BMG") staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.

I understand that information may be released to family members or others without this form, if allowed by federal and state law.

I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.

I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.

I can update this form at any time by completing a new form and giving it to BMG staff.

I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.

I understand that this is not a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Signature	_____	
Print Name	_____	
Date	___ / ___ / ____	Time ___ : ____

Relationship to Patient

Self

Legal Representative or Guardian (proof of power of attorney or legal guardianship required)

