*Welcome to our Office* **Patient Registration** ***Confidential***

Today's Date_____ Age_____ Date of Birth, Month_____ Day_____ Year_____

Patient name_____

Address_____

City_____ State_____ Zip_____

Home phone_____ Cellphone_____ Work phone_____

Driver License #_____ State_____ S.S.#_____

Sex M / F Marital status S / M / W / D / SEP Referred by_____

Patient's employer _____ Occupation_____

Work address_____

Spouse/Guardian name_____ Date of birth_____

Name of employer_____ Phone work (_____)_____

Employer address_____

Emergency contact name/relationship_____ Phone_____
*(Other than Spouse)*

*Payment Required at Time of Service.* I will be paying today by Cash_____ Check_____ MasterCard or Visa_____

Primary Insured_____ Date of birth_____

Primary Ins_____ Phone_____ Relation to patient_____

Group#_____ ID#_____

**Consent to Treatment Assignment of Benefits**

I certify that the information given by me in applying for payment is correct. I authorize George J Juetersonke DO PC or his staff to release any medical records or information that may be necessary for either medical care or processing applications for financial benefit. I understand that my **insurance may not reimburse me** for all or any expenses incurred. I further understand and agree to be ultimately responsible for the balance on my account for any services rendered. I understand that Medicare usually does **not** pay for services from this office. A photocopy of this assignment shall be as valid as the original.

I am consulting the Physician and or the Nurse Practitioner as a patient and hereby consent to treatment by the staff. The medical history and information given above is true and is presented for the sole purpose of obtaining medical counsel and treatment. As part of my medical record my photograph will be taken. It along with the above information is considered confidential. I am aware that the practice of medicine is not an exact science and I expressly acknowledge that there have been **no guarantees** made to me as to the benefits or lack of complications from treatment. **I will notify the office of any changes in the above information or my health status as they occur**. It is my responsibility to make a **follow-up appointment** in six weeks from today's appointment unless directed otherwise.

_____

**Patient signature here** Guardian's signature if pt is a minor **Todays Date**

_____

Updates only. Please do **not** sign here until directed to do so. Do **not** date here until directed. Date

**George J. Juetersonke, D.O., P.C.**
3525 American Drive
Colorado Springs, CO 80917

# Health Questionnaire

***"If you do not ask the right questions you do not get the right answers. A question asked in the right way often points to its own answer. Asking questions is the A-B-C of diagnosis. Only the inquiring mind solves problems."*** Edward Hodnett

Date:_____ Referred by:_____ Pharmacy:_____ Internet

## I. Personal Information

Name: _____ Age: _____

Birthplace: _____ Date of Birth: _____

Marital Status: ❑ Single ❑ Married ❑ Widow(er) ❑ Separated ❑ Divorced ❑ Partnered

Children: _____

Occupation: _____

Hobbies: _____

Pets: _____

Education: _____

What are your health goals? _____

_____

_____

## II. General Health Information - *(Please bring copies of recent lab)*

Height:_____ Weight: _____ Blood Pressure: _____ When last taken: _____

When and where did you have your last physical checkup?_____

Name of family physician _____

Present illness / Main concern (**single** worst): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List other concerns in order of severity: 1. _____

2. _____ 3. _____ 4. _____

Date or age main symptoms began? _____

Was there a trigger? _____

Began where? _____

How often do episodes occur? _____

How long do they last? _____

❑ Yes ❑ No Free of symptoms? When? _____

What factors do you know or suspect from your own experience cause your symptoms or make them worse? _____

_____

What makes your symptoms better? _____

_____

What kind of medical doctors or specialists have you seen for your main complaint?

_____

What was your diagnosis, what advice was given? _____

_____

Have you recently been treated by any of these types of practitioners?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ❑ Yes | ❑ No | Psychologist | ❑ Yes | ❑ No | Homeopath | ❑ Yes | ❑ No | Biofeedback |
| ❑ Yes | ❑ No | Osteopath | ❑ Yes | ❑ No | Acupuncturist | ❑ Yes | ❑ No | Naturopath |
| ❑ Yes | ❑ No | Chiropractor | ❑ Yes | ❑ No | Reflexologist | ❑ Yes | ❑ No | Nutritionist |
| ❑ Yes | ❑ No | Kinesiologist | ❑ Yes | ❑ No | Hypnotist | | | |

**Check Diagnostic Studies/Procedures you have had:**

| | | |
|---|---|---|
| Biopsy: _____ | Date: _____ | Results: _____ |
| Blood test(s): _____ | Date: _____ | Results: _____ |
| _____ | _____ | _____ |
| Cholesterol: _____ | Date: _____ | Results: _____ |
| Body Scan(s): _____ | Date: _____ | Results: _____ |
| Bone Density: _____ | Date: _____ | Results: _____ |
| Colonoscopy: _____ | Date: _____ | Results: _____ |
| Electrocardiogram: _____ | Date: _____ | Results: _____ |
| Hearing Test: _____ | Date: _____ | Results: _____ |
| Mammogram: _____ | Date: _____ | Results: _____ |
| MRI: _____ | Date: _____ | Results: _____ |
| PAP: _____ | Date: _____ | Results: _____ |
| PSA: _____ | Date: _____ | Results: _____ |
| X-rays: _____ | Date: _____ | Results: _____ |

Vaccines

| | | | |
|---|---|---|---|
| Flu: _____ | Date: _____ | TB Test _____ | Date: _____ |
| Pneumonia: _____ | Date: _____ | Menningitis: _____ | Date: _____ |
| Shingles: _____ | Date: _____ | | |
| Tetanus: _____ | Date: _____ | | |
| HPV: _____ | Date: _____ | | |

## Medications

| | Name | Dose | Frequency | Duration |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

## Supplements/Vitamins

| | Name | Dose | Frequency | Duration |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

## Allergy or Adverse Reactions *(Medications or supplements only)*

| | Substance | Reaction |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

## Surgical History

| | Surgery | Date | Reason for Surgery |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

## Immediate Family

Instructions: Please include all information you know of related to the following areas.

What is your ancestry / ethnicity? _____

| | | | | | Paternal | | Maternal | |
|---|---|---|---|---|---|---|---|---|
| | Father | Mother | Brother | Sister | Grandfather | Grandmother | Grandfather | Grandmother |
| Age if living | | | | | | | | |
| Age at death | | | | | | | | |
| Cause of death | | | | | | | | |
| Type of work | | | | | | | | |
| Asthma<br>Allergy Hives<br>Eczema | | | | | | | | |
| Blood clots | | | | | | | | |
| Weight problem | | | | | | | | |
| Tobacco use | | | | | | | | |
| Alcohol abuse | | | | | | | | |
| Mental Illness | | | | | | | | |
| Cancer | | | | | | | | |
| Diabetes | | | | | | | | |
| Hypertension | | | | | | | | |
| Heart problem | | | | | | | | |
| High cholesterol | | | | | | | | |
| Thyroid disease | | | | | | | | |
| Ulcers | | | | | | | | |
| Arthritis | | | | | | | | |
| Osteoporosis | | | | | | | | |
| Other | | | | | | | | |

## Ears, Nose, Throat

❑ Yes ❑ No Do you have ringing or buzzing in your ears?

❑ Yes ❑ No Do you have allergies? _____Chemical _____Seasonal _____Animals _____Dust _____Mold

❑ Yes ❑ No Do you have any nasal polyps?

❑ Yes ❑ No Have you had sinus infections? Within the last year? _____

❑ Yes ❑ No Hearing Aid?

❑ Yes ❑ No Do you have any decayed painful teeth or bleeding gums?

❑ Yes ❑ No Do you have persistent sores in your mouth?

❑ Yes ❑ No Do you have trouble swallowing foods?

❑ Yes ❑ No Do you often have hoarseness?

❑ Yes ❑ No Do you floss everyday?

❑ Yes ❑ No Do you have filling in your teeth? Which type? _____

## Dermatologic

❑ Yes ❑ No Do you have a chronic skin condition?
❑ Yes ❑ No Do you tend to have dandruff?
❑ Yes ❑ No Fungus?
❑ Yes ❑ No Hair falling out?
❑ Yes ❑ No Do your nails split easily?

## Eyes

❑ Yes ❑ No Dryness?
❑ Yes ❑ No Sensitive to light?
❑ Yes ❑ No Wear glasses or contacts?
❑ Yes ❑ No Glaucoma?
❑ Yes ❑ No Cataracts?
❑ Yes ❑ No Macular degeneration?
❑ Yes ❑ No Difficulty seeing at night?

## Headaches

❑ Yes ❑ No Migraine?
❑ Yes ❑ No Sinus?
❑ Yes ❑ No Tension?

Check items associated with headache:

❑ Loss of sight
❑ Dazzling lights
❑ Diarrhea
❑ Tender or painful skin
❑ Tearing of eye
❑ Nasal drip
❑ Light sensitivity
❑ Visual disturbance
❑ Noise sensitivity
❑ Queasy stomach
❑ Abdominal pain
❑ Nausea
❑ Vomiting
❑ Neck / Shoulder pain
❑ Flushing
❑ Chilly sensation

## Endocrine

❑ Yes ❑ No Do you have chronic fatigue?
❑ Yes ❑ No Do you have insomnia?
❑ Yes ❑ No Do you obtain 8 hours of sleep each night? If not, how much? _____
❑ Yes ❑ No Have you lost or gained more than ten pounds in the last year?
Lowest adult weight_____ Lbs _____ Age
Highest adult weight_____ Lbs _____ Age
❑ Yes ❑ No How much would you like to weigh? _____ Lbs
❑ Yes ❑ No Have you ever had thyroid trouble? Low? _____ High? _____
❑ Yes ❑ No Have you had hypoglycemia?
❑ Yes ❑ No Have you ever been diagnosed with metabolic syndrome or insulin resistance?

## Hematology

❑ Yes ❑ No Have you had a low white blood count?
❑ Yes ❑ No Have you ever been anemic? (Had low red blood count.)
❑ Yes ❑ No Have you taken iron pills previously?
❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Have you noticed swelling lymph glands in your neck, armpits or groin lately?
❑ Yes ❑ No Have you had blood clots?

## Chest Cardiovascular

❑ Yes ❑ No Have you had asthma? When? _____

❑ Yes ❑ No Have you ever been told you have emphysema or chronic bronchitis or another disease?

❑ Yes ❑ No Do you get out of breath easily?

❑ Yes ❑ No Do you have chest tightness?

❑ Yes ❑ No Have you recently had episodes of chest pain lasting more than one minute?

❑ Yes ❑ No Have you ever had a heart attack?

❑ Yes ❑ No Have you had an abnormal EKG?

❑ Yes ❑ No Does your heart race or skip?

❑ Yes ❑ No Have you had a heart murmur?

❑ Yes ❑ No Have you had swelling in your feet or ankles?

❑ Yes ❑ No Do you have high blood pressure?

How far can you walk vigorously before becoming short of breath? _____

## Gastrointestinal

❑ Yes ❑ No Were you ever treated for ulcers?

❑ Yes ❑ No Have you had black bowel movements?

❑ Yes ❑ No Have you had blood in your stools, even in small amounts?

❑ Yes ❑ No Have you ever had yellow jaundice or hepatitis?

Check symptoms that apply:

❑ Heartburn
❑ Bloating
❑ Cramping
❑ Use laxatives
❑ Mucus in stools
❑ Nausea
❑ Indigestion
❑ Flatulence
❑ Queasy Stomach
❑ Diarrhea
❑ Gallbladder trouble
❑ Abdominal pain
❑ Belch frequently
❑ Stomach aches
❑ Constipation
❑ Anal itching
❑ Hemorrhoids

## Urinary

❑ Yes ❑ No Do you usually have to get up at night to urinate? How many times? _____

❑ Yes ❑ No Do you void only small amounts of urine each time you go?

❑ Yes ❑ No Does it hurt to urinate?

❑ Yes ❑ No Do you lose urine when you cough or sneeze?

❑ Yes ❑ No Have you ever had kidney stones? What kind? _____

Sexually attracted to: ❑ Male ❑ Female ❑ Both

## Neurology

❑ Yes ❑ No Have you had head injuries?

❑ Yes ❑ No Have you ever had blackout spells? If so, when? _____

❑ Yes ❑ No Have you ever had seizures (convulsions)? If so, when? _____

❑ Yes ❑ No Have you ever lost your ability to speak?

❑ Yes ❑ No Are there times when you have trouble thinking clearly or explaining what you mean?

❑ Yes ❑ No Were you ever told you had learning disabilities or dyslexia?

## Skeletal

❑ Yes ❑ No Do you have arthritis? What kind? _____

❑ Yes ❑ No Do you have fibromyalgia?

❑ Yes ❑ No Do you have muscle spasms, pain, fatigue?

❑ Yes ❑ No Do you experience restless legs?

## Women Only

## Preimenopause/Menopause Symptoms

Check all symptoms you are currently experiencing:

❑ Hot flashes ❑ Irregular or absent menstrual cycles ❑ Lack of sexual desire/orgasm ❑ Memory loss

❑ Mood swings ❑ Night sweats ❑ Skin wrinkles ❑ Vaginal dryness ❑ Other _____

## Sexual/Reproductive

First day of last menstrual period? _____

❑ Yes ❑ No Do you have heavy bleeding and/or painful menstrual cycles?

❑ Yes ❑ No Have you been diagnosed with PMS (Premenstrual Syndrome) or PMDD (Premenstrual Dysphonic Disorder?

❑ Yes ❑ No Have you been diagnosed with PCOS (Polycystic Ovarian Syndrome)

❑ Yes ❑ No Are you currently using contraception? If “yes,” what method? _____

❑ Yes ❑ No Are you trying to get pregnant?

❑ Yes ❑ No Have you had more than 1 miscarriage?

❑ Yes ❑ No Have you ever had a high risk pregnancy, premature delivery, or other complication of pregnancy/delivery?

Describe: _____

How many times have you been pregnant? _____

How much did your largest baby weigh? _____

❑ Yes ❑ No Are you currently sexually active?

❑ Yes ❑ No Is intercourse painful?

❑ Yes ❑ No Have you ever had an abnormal pap smear? If “yes”, when_____ Results_____

❑ Yes ❑ No Have you ever been diagnosed with Genital Herpes or HPV (Human Papilloma Virus)?

❑ Yes ❑ No Have you ever been treated for other sexually transmitted infections?

❑ Yes ❑ No Are you currently experiencing abnormal vaginal discharge?

❑ Yes ❑ No Are you experiencing low libido/lack of sexual desire?

## Men Only

❑ Yes ❑ No Discharge from penis? Sores on penis?

❑ Yes ❑ No Lump or pain in testicle(s)?

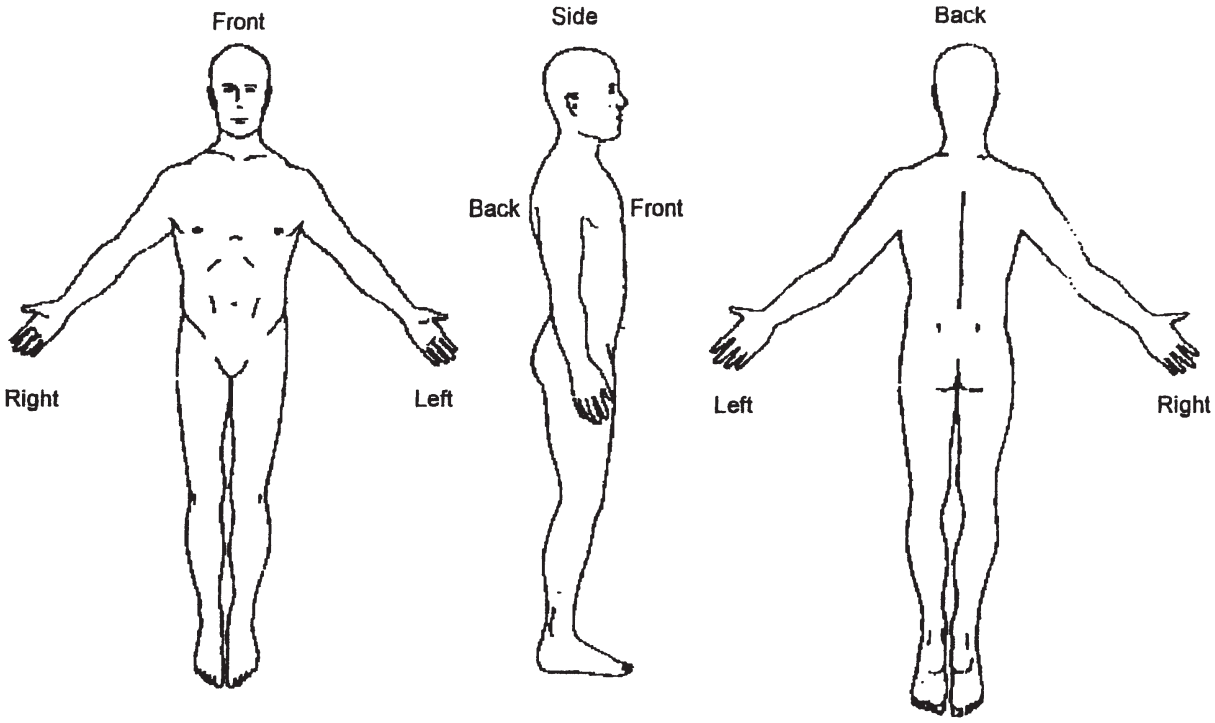
❑ Yes ❑ No Do you have a decrease in libido?

❑ Yes ❑ No Are your erections less strong?

❑ Yes ❑ No Inability to achieve or sustain an erection?

## Headache, Nerve, Muscular or Skeletal Pain

❑ Yes ❑ No Please color on the picture where you have pain or other symptoms. Include symptoms of pain, numbness or tingling.




❑ Yes ❑ No Are there foods that make your symptoms better? Worse? Explain: _____

_____

_____

❑ Yes ❑ No Do you feel better if you skip a meal? _____

❑ Yes ❑ No Have you ever fasted? When? _____ For How Long? _____

❑ Yes ❑ No Are there foods you occasionally crave? Explain: _____

_____

If you could not eat for several days, what food or foods would you miss the most? _____

_____

Are most of your meals _____ at home _____ at restaurants

Please list what you typically eat for:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____ Beverages: _____

_____

_____

## Personal Habits

**Do you consider your health to be:** ❑ Excellent ❑ Good ❑ Fair ❑ Poor

How often do you exercise? ❑ At least 3 times a week ❑ Occasionally ❑ Rarely ❑ Never

If you exercise, what do you do? _____

For how long and how often? _____

### Tobacco Use

❑ Yes ❑ No Do you currently smoke cigarettes?

If yes, how many per day? _____ When did you start? _____

If you do not currently smoke cigarettes, have you ever smoked? ❑ Yes ❑ No

If yes, when did you start? _____ How many per day? _____ When did you stop? _____

Do you use any other type of tobacco? ❑ Yes ❑ No If yes, what? _____

### Alcohol and Drug Use

❑ Yes ❑ No Do you drink alcohol? If yes, how many drinks do you have each week? _____

❑ Yes ❑ No Do you ever have a drink in the morning to help you get going?

❑ Yes ❑ No Have you ever tried to cut down on your drinking?

❑ Yes ❑ No Have you ever felt guilty about the amount you drink?

❑ Yes ❑ No Have you ever been an alcoholic?

❑ Yes ❑ No Do you use recreational drugs?

### Abuse

❑ Yes ❑ No Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

❑ Yes ❑ No Within the last year, has anyone ever forced you to have sexual activities?

❑ Yes ❑ No Do you feel you are verbally or emotionally abused by someone?

❑ Yes ❑ No Have you had counseling for these issues?

### Stress Management

How do you handle stress? ❑ Very well ❑ Moderately well ❑ Poorly

Check all the stressors, if any, that apply to you:

❑ Family member(s) ❑ Financial ❑ Health issues ❑ Job/Professional Issues

What do you do to relax? _____

❑ Yes ❑ No Is your hostility easily aroused?

❑ Yes ❑ No Do you show aggressive impatience with anyone or anything that delays you?

❑ Yes ❑ No Do you get enough leisure time?

❑ Yes ❑ No Are you usually happy?

❑ Yes ❑ No Do you have too many responsibilities?

❑ Yes ❑ No Is your job satisfying to you?

❑ Yes ❑ No Is your job upsetting you?

❑ Yes ❑ No Are you usually satisfied with medical advice?

❑ Yes ❑ No Do you have periods of worry or feeling tense?

❑ Yes ❑ No Do you feel depressed or lonely?

❑ Yes ❑ No Do you have crying spells?

## Health Maintenance

❑ Yes ❑ No Do you have carbon monoxide and smoke detectors in your home?
When did you last check the batteries? _____
❑ Yes ❑ No Do you wear seat belts ALL of the time?
❑ Yes ❑ No Do you talk or text on your cell phone while driving?
❑ Yes ❑ No Do you use sunscreen?
❑ Yes ❑ No Do you have an advanced directive, living will, and health care power of attorney?
How many hours per week do you spend?
Watching TV_____ Internet_____ Cell Phones/Texting_____
Computer other than work_____ Video Games/Movies _____

**Thank you for the effort put into completing your health questionnaire!**

***"The secret of the care of the patient is in caring for the patient."***
Francis Weld Peabody
1881-1927

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