Medical History

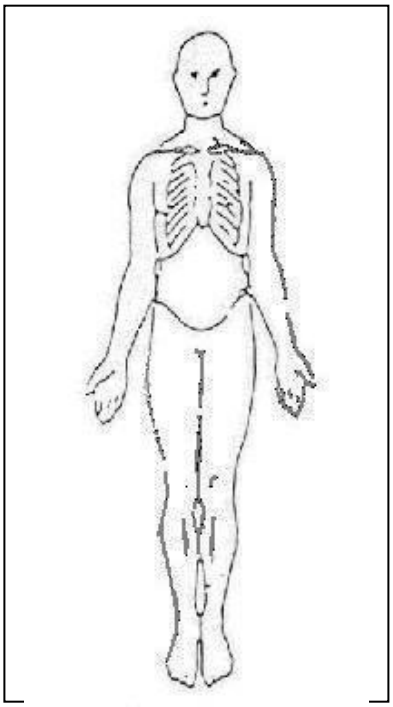
Chief Complaint_____

_____

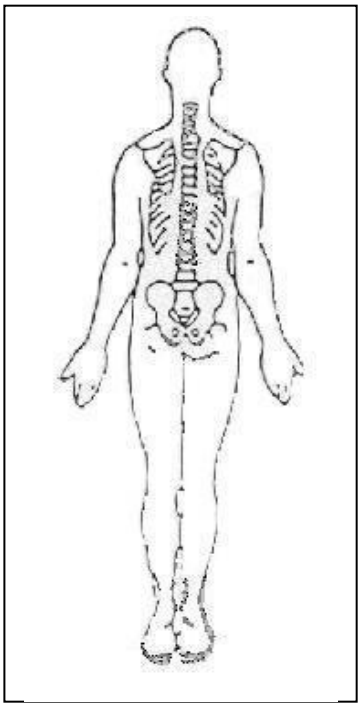
Current Medications_____

Allergies to Medications/Other_____

Do you have any allergies to latex? _____ Exercise (type/how often) _____



Anterior: Shade in Regions of Pain



Posterior: Shade in Regions of Pain

Hospitalizations

Year	Operation/Illness	Hospital	City/State

First: _____

Second: _____

Third: _____

Family Medical History

Please mark any conditions that have been suffered by a blood relative. Also indicate which relative.

( ) Allergies
( ) Cancer
( ) Glaucoma
( ) Stroke
( ) Mental Illness
( ) Asthma
( ) Alcoholism
( ) Genetic Diseases
( ) Ulcers
( ) Heart Disease
( ) Anemia
( ) Diabetes
( ) Gout
( ) Tuberculosis
( ) Blood Clotting Problems
( ) Arthritis
( ) Epilepsy
( ) Headaches
( ) Kidney/Bladder Problems
( ) High Blood Pressure
( ) Other_____

Personal Medical History

Please place a check next to those conditions that you have had in the past and that are no longer present. Circle those conditions that you are currently experiencing. Also indicate your age at the onset of these conditions

( ) Failing Vision
( ) Double/Blurred Vision
( ) Eye Pain
( ) Eye Infections
( ) Decreased Hearing
( ) Ringing/Buzzing in Ears
( ) Ear Infections
( ) Allergies/Hay Fever
( ) Sinus Trouble
( ) Nose Bleeds
( ) Frequent Sore Throats
( ) Prolonged Hoarseness
( ) Thyroid Disease
( ) Asthma
( ) Emphysema
( ) Chronic Cough
( ) Bronchitis
( ) Pneumonia
( ) Short Breath-On Exertion
( ) Short Breath-Lying Flat
( ) Chest Pains
( ) Heart Murmurs
( ) Palpitations
( ) Swollen Ankles
( ) Fainting Spells
( ) Leg Pain/Walking
( ) Varicose Veins
( ) Recent Loss of Appetite
( ) Difficulty Swallowing
( ) Heart Burn
( ) Persistent Nausea/Vomiting
( ) Ulcers
( ) Chronic Abdominal Pain
( ) Recent Change-Bowel Habits
( ) Diarrhea
( ) Difficulty Sleeping
( ) Constipation
( ) Black or Tarry Stool
( ) Red Blood in Stool
( ) Hemorrhoids
( ) Diverticulosis
( ) Hernia
( ) Bladder Infections
( ) Kidney Infections

( ) Pain on Urination
( ) Poor Control of Urination
( ) Decreased Force of Urination
( ) Blood in Urine
( ) Kidney Stones
( ) Sexually Transmitted Disease
( ) Chronic Fatigue
( ) Recent Weight Loss
( ) Excessive Weight Gain
( ) Anemia
( ) Bruise Easily
( ) Cancer
( ) Diabetes
( ) Convulsion/Seizures
( ) Stroke
( ) Tremors
( ) Muscle Weakness
( ) Numbness/Tingling Sensation
( ) Frequent Headaches
( ) Migraine Headaches
( ) Broken Bones: _____
_____
( ) Arthritis
( ) Osteopenia
( ) Osteoporosis
( ) Gout
( ) Cold or Numb Feet
( ) Rashes
( ) Psoriasis
( ) Eczema
( ) Hives
( ) Nervousness
( ) Anxiety Depression
( ) Memory Loss
( ) Moodiness
( ) Alcoholism
( ) Phobias
( ) Mumps
( ) Measles
( ) German measles
( ) Chicken Pox
( ) Polio
( ) Gall Bladder Problems
( ) Jaundice/Hepatitis

( ) Scarlet Fever
( ) Rheumatic Fever
( ) Tuberculosis
( ) Malaria
( ) Mononucleosis
( ) Recreational Drug Use
( ) Alcohol: _____
( ) Cigarettes _____
Packs per Day _____
( ) Coffee_____
Cups per Day_____

( ) Other Conditions not listed above:

_____

_____

_____

_____

_____

_____

Live Births_____

Miscarriages_____

Birth Control Type_____

Age/Onset of Menses_____

( ) Regular Period ___Y ___N

( ) Light Flow

( ) Moderate Flow

( ) Heavy Flow

Length of Flow_____

Length of Cycle_____

( ) Pain/Bleeding with
Intercourse ___Y ___N

( ) PMS (Moderate to Severe)

Practice Policies

Emergencies	During non-business hours we will refer you to your local Emergency department or primary care physician..
Cancellations/Missed Appointments	Our office does not double book or over book. Our office has a minimum 24 hour cancellation policy. If this is not possible, please call us as early as possible. Please cancel Monday appointments the previous Friday. Failing to cancel an appointment in advance may result in a $50.00 charge for the missed appointment.
Scheduling	Appointments are scheduled back to back. The doctor does not have the freedom to spend additional time with a patient who arrives late.
Payment	Payment is requested and expected at the time service is provided. We accept all major credit cards, personal checks and cash.
Returned Checks	A fee of $45.00 will be applied to each returned check.
Insurance(s)	Our office does not participate with any insurance carrier, Medicare, TRICARE or Workers' Compensation. Our office will provide you with a statement that you can submit to your carrier to request reimbursement. If you are covered by Medicare or TRICARE, please notify the front office staff. We have "Opted-out" of Medicare. We are classified as a "non-authorized" TRICARE provider. Under the law, MEDICARE PATIENTS CANNOT SUBMIT TO MEDICARE; TRICARE PATIENTS CANNOT SUBMIT TO TRICARE, however, if you have secondary (supplemental) insurance, you may submit to them. However, be aware that supplemental insurance plans may elect not to make payment for items and services furnished by the physician.
Authorization	I hereby authorize Falls Church Osteopathic Medicine, LLC to release to my insurance carrier any information needed to process my insurance claim. I understand that payment for services rendered is due and payable by me regardless of any insurance coverage. I also agree to pay for the cost of collections should my account become delinquent including reasonable attorney fees.
Consent	Due to health risks involved with accidental needle sticks, in the event of an accidental needle stick incurred by any personnel, I hereby give my permission to have my blood drawn for testing, at no cost to the patient.
Privacy Policy	My signature below acknowledges that a copy of the Notice of Privacy Practices of Falls Church Osteopathic Medicine, LLC has been made available to me and that I have read the Notice of Privacy Practices.

_____ _____

Print Name Date

_____

Signature

Falls Church Osteopathic Medicine, LLC

Gregory J. Craddock, D.O., DAOBFP
313 Park Avenue, Suite G-9, Falls Church, Virginia 22046
P 703-241-1033 F 703-241-1035

New Patient Registration Sheet

Name_____ Date_____
First Last Middle Initial

Street Address_____ Apt. #_____

City_____ State_____ Zip_____

Date of Birth _____/_____/_____ Age _____

Home Telephone ( )_____ Cell ( )_____

Work Telephone ( )_____

Marital Status: S M D W Sex: Male Female

Employer_____

Address_____

Emergency Contact _____ Phone ( ) _____

Referral Source _____

Insurance company* (name only)_____

Please Note

**If you are covered by Medicare, TRICARE, please inform our front office staff*