DR. VANCE HARRIS M.D. LICENSE #G057356

. 2632 Edith Ave. Suite B Redding California 96001 (530) 242-1227

Patient Name:_____ Date of Birth:_____

Gender: M F Social Security Number_____

Home Phone:_____ Work:_____ Cell:_____

Mailing Address:_____

City:_____ Zip:_____ State:_____

Employer:_____ Phone:_____

Name of Spouse:_____ Date of Birth_____

Emergency Contact (if not spouse) _____Phone #_____

*Primary Insurance:_____

Subscriber Name:_____ Date of Birth_____

*Secondary Insurance:_____

Subscriber Name:_____ Date of Birth_____

**( IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING INFORMATION )**

Mothers Name_____ Date of Birth_____

Address(if different than above)_____

Phone Number_____

Fathers Name_____ Date of Birth_____

Address(if different than above)_____

Phone Number_____

# Patient History Form

Dr. Vance Harris- 2632 B. Edith Ave. Redding, CA. 96001. (530) 242-1227

**Please take the time to fill out this medical history. All of this information is important.**

**PAST MEDICAL HISTORY:** Check conditions that doctors have followed you for in the past

Please List any Additional Medical Conditions you know of:

☐ High blood pressure/hypertension ☐ High Cholesterol ☐ Liver Disease ☐ Diabetes ("sugar")

☐ Thyroid Problems ☐ Kidney Disease ☐ Heart Attack/By-pass Surgery

☐ Heart Failure ☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Stroke

☐ Seizures/Epilepsy ☐ Stomach Problems ☐ Intestinal Problems ☐ Reflux Disease

☐ Glaucoma ☐ Psychiatric Illness ☐ Arthritis ☐ Abnormal PAP

Cancer: Type & Location _____

Other Medical Conditions: (Please list out any additional health conditions.)

| | |
|---|---|
| | |
| | |
| | |

**SURGICAL HISTORY** (Please list all prior operations and dates):

| | |
|---|---|
| | |
| | |
| | |

**Allergies to Medications:** _____

**Allergies (Other):** _____

**Medications:** (Please list all of your current medications including strength and how many a day)

| Medication | Strength | Frequency in a day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**HEALTH MAINTENANCE SCREENING TESTS:**

Colonoscopy - Date _____ Polyp? ☐ No ☐ Yes

Mammogram - Date _____ Abnormal? ☐ No ☐ Yes

Pap Smear - Date _____ Abnormal? ☐ No ☐ Yes

Bone Density Test - Date _____ Abnormal? ☐ No ☐ Yes

**IMMUNIZATIONS:** Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the formation. ☐

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot or illness _____

Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____

MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

**Adopted** – Yes No (Please Circle) If yes and you do not know your family history skip this section.

**FAMILY HISTORY:** Indicate diseases/illnesses in your family (parents and siblings are most important). Check yes/no box for living or not and list age of death.

Mother ☐Yes ☐No _____ _____

Father ☐Yes ☐No _____ _____

Sisters ☐Yes ☐No _____ _____

☐Yes ☐No _____ _____

Brothers ☐Yes ☐No _____ _____

☐Yes ☐No _____ _____

Has any member of your family had any of the following illnesses?

List which family member (parents, grandparents, children, cousins, aunts, uncles etc)

Anemia or Blood disease _____

Cancer _____

Diabetes _____

Glaucoma _____

Heart disease _____

High blood pressure _____

HIV disease / AIDS _____

Mental Illness / Depression _____

Stroke _____

_____

**Exercise:** Do you exercise regularly? ☐ Yes ☐ No
What kind of exercise? _____
_____

How long (minutes)? _____ How often? _____

**Diet:** How would you rate your diet? ☐ Good ☐ Fair ☐ Poor

_____

## OTHER HEALTH ISSUES:

| | |
|---|---|
| **Tobacco Use**<br>Smoke cigarettes: ☐ Never ☐ No ☐ Yes<br>(If you never smoked please go to alcohol use question now)<br>Quit date: _____<br>How many years did you smoke? _____<br>Approximately how many packs a day did you/ do you smoke? _____<br>Current smoker: # of years as a smoker: _____<br>Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew | **Alcohol Use**<br>Do you drink alcohol? ☐ No ☐ Yes<br><br># of drinks/week: _____<br><br>☐ Beer ☐ Wine ☐ Liquor |
| Do you currently drink coffee and/or tea? ☐Yes ☐No<br>if yes, how many cups per day?<br>_____ | **Drug Use**<br>Do you use marijuana or recreational drugs? ☐ No ☐ Yes<br>Have you ever used needles to inject drugs? ☐ No ☐ Yes |

**Sexual Activity**

Sexually involved currently: ☐ No ☐ Yes

Sexual partner(s) is/are/have been: ☐ male ☐ female

Birth control method (circle below all that apply): ☐ None needed

Condom, pill, diaphragm, vasectomy, other _____

## OCIAL HISTORY:

Occupation (or prior occupation): _____

Retired/unemployed/leave of absence/disabled (circle one)

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____

Number of children: _____ Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____

Who lives at home with you? _____

## WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

## SOCIOECONOMICS:

**Ethnic Background:** How would you best describe yourself?

(circle only one)

Asian, Black, Hispanic

Native American, Native Hawaiian & Other Pacific Islander

White, Other, Decline

**Education completed:** Grade school/ High school / College Graduate school

Vance Harris, M.D.
2632 Edith Ave. Suite B
Redding, CA. 96001

(530) 242-1227

Patient Name:_____ Date:_____

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Our commitment to privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. Your PHI will not be sold or transmitted to any entity unless written and legal authorization is obtained from you. We also are required by the law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may crate or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

Insurance Authorization/Financial Responsibility

I understand that payment is requested and expected at time services are rendered. I authorize my provider to bill my insurance carrier and for my insurance carrier to release payment of my services to my provider. I fully understand that my co-pay is due at the time services are rendered. I will pay in a timely manner. I am aware that there is a $25.00 fee on all returned checks.

Signed:_____ Date_____
*Responsible party for payment must be Parent/Guardian if patient is a minor

Authorization/Consent to treat a minor

I certify that I am a legal guardian of the above mentioned minor and have full legal rights to consent to the treatment of the mentioned minor.

Signed:_____Date_____

Dr. Vance Harris 2632 Edith Ave Ste B Redding Ca 96001

PAITIENT NAME:_____

Please list persons below that Dr. Harris and staff have permission to discuss your health issues, prescriptions and test results with:

1._____

2._____

3._____

4._____

5._____

SIGNATURE_____DATE_____