James Covalesky, D.O.

Patient Information

Date: _____

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____ Sex: ☒ M ☒ F Social Security Number: _____

Marital Status: (Please Circle) Single Married Widowed Divorced

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____@ _____.com

How would you prefer to be contacted?: _____

How did you hear about us?: _____

EMPLOYMENT

Occupation: _____ Employer Name: _____

Employer Address: _____

Employer Phone: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Emergency Contact Relation: _____ Emergency Contact Number: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Address/Telephone of Insurance Co:
_____

_____

ID#: _____ Group Number: _____ Co-Pay:
_____

Name of Policy Holder (Please complete if not SELF) : -
_____

Policy Holder Date of Birth: _____ Policy Holder Social Security Number:
_____

Policy Holder Address:
_____

City: _____ State: _____ Zip Code:
_____

Policy Holder Sex: ☒ M ☒ F Policy Holder Marital Status: (Please Circle) Single Married Widowed Divorced

Secondary Insurance Carrier:
_____

Address/Telephone of Insurance Co:
_____

_____

ID#: _____ Group Number: _____ Co-Pay:
_____

Name of Policy Holder:
_____

Policy Holder Date of Birth: _____ Policy Holder Social Security Number:
_____

Pharmacy Name: _____ Pharmacy Phone Number:
_____

Pharmacy Address:
_____

Drug Allergies

Drug: _____ Reaction:
_____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Social History

Do you smoke? ☒ Yes ☒ No ☒ Past How much? _____

Do you drink? ☒ Yes ☒ No ☒ Past How much? _____

Have you ever had a problem with drugs? ☒ Yes ☒ No
Describe:_____

Do you exercise regularly (how much)? _____

List all medications currently being taken and explain what each medication is for (include over the counter medications, vitamins, cartilage supplements and birth control pills):

Drug: _____ Dosage : _____ How often Taken: _____

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Drug: _____ Dosage : _____ How often Taken: _____

Past Medical History

Please list any and all surgeries Approximate Year

_____ _____

_____ _____

_____ _____

_____ _____

Please list any specialists you are currently seeing and their numbers:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please Circle if you've had any of the following conditions:

Coronary Artery Disease Stroke Depression Kidney Disease Liver Disease

Kidney Stones Gout GERD/Reflux Anxiety
Osteoporosis

Hypertension COPD High Cholesterol Heart Disease
Hyperthyroidism

Tuberculosis Diabetes Pulmonary Embolism Migraines
Hypothyroidism

Fibromyalgia Asthma Diverticulitis

Cancer Type:
_____

Females Only
Last Menstrual Period: _____ If post menopausal, Age at menopause:
_____

Family History

Relative	Problem	Onset Age	Currently Living?	If No Age of Death
___Mother_____	_____	_____	Y or N	_____
___Father _____	_____	_____	Y or N	_____
_____	_____	_____	Y or N	_____
_____	_____	_____	Y or N	_____
_____	_____	_____	Y or N	_____