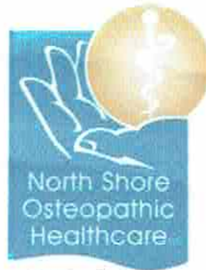

1732 1st Street
Highland Park, IL 60035
Phone: (847) 242-1210
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New Patient Information and Consent Form

Patient's name____ M____ F___ Birth Date _______________

Patient's address ____

____

Email:____

Telephones: home___________________ work______________ cell _______________________

single___ married___ other___ children ____

Occupation ____

Patient's employer or school

____

Patient's Primary Care Physician (and/or Referring Physician)

____

Emergency Contact Info:

Name: ____________________ Relationship: _________________ Phone: __________________

Where did you hear about us/referred by?:

____

New Patient Health History

Name: ______________________________ Date of Birth: ____________ Age: _____

STATE CURRENT HEALTH CONCERN(S):

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

Current Symptoms (be as descriptive as possible)

____

____

____

____

What makes it better, what makes it worse?

____

____

How did this condition start?

____

____

____

What type of workup have you had (doctors seen, tests performed, etc.)?

____

____

____

What treatments have you tried? How well have they worked?

____

____

____

CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage please):

____

____

____

____

CURRENT MEDICAL CARE:

Primary Care Provider (name, practice name or location):

____

Approximate date of last physical examination: ____________ by whom? ____________________

Other health care professional(s) you are seeing and for what conditions: ____________________

____

Would you like us to send a copy of your office visit note to your PCP or other providers?____________

ALLERGIES? (include reactions to medicines): ______________________________

PAST MEDICAL HISTORY: Please list all major illnesses, injuries, traumas (including emotional), and surgeries w/ year

____

____

____

DIGESTIVE:

___ trouble swallowing ___ heartburn ___ poor appetite ___ nausea ___ vomiting (with blood?)

___ diarrhea ___ constipation ___ excess belching or passing gas ___ change in stool (with blood?)

___ hemorrhoids ___ rectal pain ___ jaundice ___ gallbladder pain

URINARY:

___ burning with urination ___ frequent urination ____ change in urine stream (with blood?)

___ frequent urinary infection ___ lose urine if you cough or sneeze ___ kidney stones

MUSCULOSKELETAL:

___ pain in muscles or joints ___ morning stiffness ___ backache ___ sciatica ___ low back pain ___ arthritis

___ gout ___short leg ___ wear a shoe lift ___ scoliosis __muscle spasms

NEUROLOGICAL:

___ blackouts ___ seizures ___ numbness or loss of sensation ___ tingling or "pins and needles"

___ tremors or other involuntary movements ____ weakness in arms or legs ___ trouble walking

OTHER:

___ heat or cold intolerance ___ excessive sweating ___ excessive thirst or hunger ___excessive urination

___ nervousness ___ tension ___depression ___ difficulty with memory ___ skin changes / rash

MALE PATIENTS:

___ urinary stream slower, smaller or split ___ lumps or pain in testicles ___ erection problems ___ sores

FEMALE PATIENTS:

___ breast tenderness or pain ___ breast lumps ___ nipple discharge ____ hot flashes

___ change in menstrual cycle, bleeding or pain ___ vaginal sores or discharge ___ painful intercourse

Age your periods began: _____ Number of days period lasts: _____ Date of last period ___________

Number of pregnancies ______ Number of deliveries ______ Age at menopause: _____

Birth control method: ____ ;

PAIN PATTERNS CHART>>>>>>>>>>>>>>>>>>>>

On the figures provided to the right, please

"illustrate" your areas of pain and/or numbness,

using the following key:

Moderate Pain	=	o o o o o
Severe Pain	=	x x x x x
Numbness	=	N N N N N

right left left right

LIFESTYLE:

How many hours of sleep do you get a night? ___________

How many cups or glasses do you drink per day: water:______ milk:____ caffeinated beverages:______

How many alcoholic beverages do you drink per week: ___________Tobacco: _____________ Drugs___________

How much exercise per week (what kind?) ____

What do you do for fun? ____

FAMILY MEDICAL HISTORY: (please list any conditions that run in the family, indicate if alive or deceased)

Mother____

Father ____

Siblings____

"REVIEW OF SYMPTOMS" Check off any of the following symptoms you have/had *recently* experienced:

GENERAL: HEAD:

___ weight change ___ headaches ___ eye pain ___ runny nose ___ painful teeth

___ tired/weak ___ glaucoma ___ hearing loss ___ stuffy nose ___ bleeding gums

___ dizzy/fainting ___ cataracts ___ noise in ears ___ nosebleeds ___ dentures

___ fever/chills ___ blurry vision ___ earaches ___ sore throats ___ goiter

___ hearing aids ___ voice change ___ swollen glands

RESPIRATORY:

___ cough ___ cough with phlegm ___ cough with blood ___ wheezing ___ short of breath

HEART & CIRCLATION:

___ high blood pressure ___ heart races or skips beats ___ chest pain ___ short of breath after climbing steps

___ short of breath while laying in bed ___ legs swell ___ legs hurt or cramp when walking ___ varicose veins

Fees: Initial Assessment/Interview: $175 Follow-up visit: $125

Informed Consent to Treatment and/or Evaluation

I hereby authorize the treatment and/or evaluation of myself (or the above named child) by Dr. Joseph Starkman (or his associate). I have discussed stated goals of treatment and/or evaluation and I understand that I have the right to ask for information regarding diagnosis, goals for treatment, and estimated length of treatment.

I understand that notes/records taken by Dr. Starkman (or his associate) represent personal work product of my physician and as such, remain his sole property. I understand and agree that Dr. Starkman (or his associate) may properly retain such documents in my file according to professional standards. He is not required to release personal notes about my care, since these represent work product, and are not part of the formal medical record. Copies of actual records and/or typewritten reports about my care can be sent out if I provide proper written authorization, and this will be done according to professional standards. There may be a fee for preparing and sending records.

In the event of a life-threatening emergency, I can reach Joseph Starkman D.O. by calling (847) 242-1210 and leaving a message. I also understand that if a life is in imminent danger, I will not wait for Joseph Starkman, D.O. to respond. I will immediately call 911 or go to the nearest emergency room for assistance.

I understand that this agreement becomes part of my medical record, which is accessible to the parties at will, but to no other person without written consent.

____ ____________

Signature of Patient, Parent or Guardian