

DEMOGRAPHICS

Patient's Name (First, Middle, Last): _____ Date of Birth: ___/___/___

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Cell Phone#: _____ Home Phone #: _____ Work#: _____

Sex: Male Female SS#: _____ Are you employed? Full Time Part-Time Retired Disabled

Marital Status: Single Married Divorced Widowed How did you hear about us? _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Pharmacy Name: _____ Pharmacy Address or Intersection: _____

Ethnicity: Asian Black or African American Caucasian Hispanic Other: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID#: _____

Name of Policy Holder: _____ DOB: ___/___/___ Group#: _____

Secondary Insurance: _____ Member ID#: _____

Name of Policy Holder: _____ DOB: ___/___/___ Group#: _____

OTHER HEALTH CARE PROVIDERS

Use	Type of Practitioner (e.g., PCP, Cardiologist, Podiatrist, etc)	Name	Office
1.	_____	_____	<input type="checkbox"/> _____
2.	_____	_____	<input type="checkbox"/> _____
3.	_____	_____	<input type="checkbox"/> _____
4.	_____	_____	<input type="checkbox"/> _____
5.	_____	_____	<input type="checkbox"/> _____

PERSONAL HISTORY

I HAVE NO PAST MEDICAL HISTORY

<u>EYES/EAR/NOSE/THROAT</u>		<u>MUSCULOSKELETAL/RHEUM</u>		<u>BLOOD/LYMPHATIC/CANCER</u>	
Cataracts	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Anemia/Low blood counts	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>			Cancer: (Type: _____)	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<u>SKIN</u>		Easy bleeding	<input type="checkbox"/>
Cold sores (canker sores)	<input type="checkbox"/>	Eczema/Dry skin (circle one)	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>
	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Transfusion	<input type="checkbox"/>
<u>CARDIOVASCULAR</u>		<u>NEUROLOGIC</u>		<u>ALLERGIC/IMMUNOLOGIC</u>	
Heart attack/Heart disease	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Hay fever/Pollen allergy	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	Seizures/Fits/Epilepsy	<input type="checkbox"/>		<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<u>INFECTIONS</u>	
Pacemaker	<input type="checkbox"/>			AIDS/HIV	<input type="checkbox"/>
PAD (Peripheral artery disease)	<input type="checkbox"/>			Genital infections (e.g., herpes, chlamydia/gonorrhea, warts)	<input type="checkbox"/>
		<u>PSYCHIATRIC/DEPENDENCY</u>		Hepatitis: Circle which: A B C)	<input type="checkbox"/>
<u>PULMONARY</u>		ADD/ADHD	<input type="checkbox"/>	Measles/Mumps/Rubella	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Alcohol/Drug Dependency	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>
COPD / Emphysema	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Shingles	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>
		Depression	<input type="checkbox"/>		
<u>GASTROINTESTINAL</u>		Eating disorder: anorexia/bulimia	<input type="checkbox"/>	<u>MEN ONLY</u>	
Colon polyps	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	Enlarged prostate (BPH)	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>			Erectile dysfunction/impotence	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<u>ENDOCRINE</u>		Prostatitis	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	Diabetes (sugar)	<input type="checkbox"/>		
Reflux (GERD)	<input type="checkbox"/>	Hyperthyroid (high thyroid)	<input type="checkbox"/>	<u>WOMEN ONLY</u>	
Ulcers (stomach, duodenal)	<input type="checkbox"/>	Hypothyroid (low thyroid)	<input type="checkbox"/>	Menopausal symptoms	<input type="checkbox"/>
		High cholesterol	<input type="checkbox"/>	Abnormal uterine bleeding	<input type="checkbox"/>
<u>GENITOURINARY</u>		Infertility (pregnancy problems)	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>
Kidney/bladder infections	<input type="checkbox"/>	Osteoporosis /Osteopenia	<input type="checkbox"/>	Premenstrual Syndrome (PMS)	<input type="checkbox"/>

Other medical history: _____

Family History

Other											
Father											
Mother											
Sister											
Brother											
PGM											
PGF											
MGM											
MGF											

MEDICATIONS

Please bring your medications in the bottles or a complete medication list to your appointment.

If there are more than 10 medications please attach a list.

Do you have problems remembering to take your medications? Yes No

	Medication Name	Dosage	Times Per Day
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		
6.	_____		
7.	_____		
8.	_____		
9.	_____		
10.	_____		

MEDICATION ALLERGIES

NO KNOWN ALLERGIES

	Medication Name	Reaction	Age When Occurred
1.	_____		
2.	_____		
3.	_____		
4.	_____		

Have you had any significant hospitalizations? If so, please specify:

	Reason for Hospitalization	Year
1.	_____	_____
2.	_____	_____
3.	_____	_____

SURGICAL HISTORY

SURGICAL HISTORY	DATE	SURGICAL HISTORY	DATE
Angioplasty/Stent	_____	Gastric bypass	_____
CABG (Heart bypass)	_____	Heart Valve	_____
Defibrillator	_____	Hernia repair	_____
Appendectomy	_____	Hysterectomy	_____
Knee Replacement	_____	Mastectomy	_____
Hip Replacement	_____	Thyroidectomy	_____
Back Surgery	_____	Tonsillectomy	_____
Carpal tunnel release	_____	Pacemaker	_____
Cataract extraction	_____	Prostate surgery	_____
Fracture	_____	Biopsy (location)	_____
Gallbladder Removal	_____		

Other _____

SOCIAL HISTORY

Have you experienced a fall in past 12 months? Yes No If yes, how many times have you fallen? _____

Do you have a Living Will/Durable Power of Attorney? Yes No

If yes, please bring copies. If no, are you interested in completing one? Yes No

Living arrangements (check all that apply)

I live with my spouse/partner I live alone I live alone but have friends who check on me regularly

I have family close by who can help me Assisted Living/Group Home Nursing Home

Are you sexually active? Yes No Men Only Women Only Both Men and Women

of partners in the last 12 months: 1 2 3 ≥3 Do you always use protection? Yes No

WOMEN ONLY

Have you ever had an abnormal pap smear? Yes No

Have you ever had an abnormal mammogram? Yes No

When was your last menstrual period? _____

Do you use contraception? Yes No If yes, what? _____

DEPRESSION SCREENING					
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the	Nearly every day	
Little interest or pleasure in doing things					
Feeling down, depressed, or hopeless					
ALCOHOL AND DRUG HISTORY					
In the past month... (circle the appropriate answers)					
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	≥ 4 times a week
How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	≥ 10
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Almost daily
Do you currently smoke?	Yes	No	How much? _____cigarettes/day OR _____packs/day How many years have you smoked this much? _____		
Are you a former smoker?	Yes	No	I quit in _____but smoked _____packs a day for _____ yrs		
Have you ever used street drugs?	Yes	No	What drugs? _____		

Have you had any of the following? (if yes, enter date to those that apply)

Test	Date	Test	Date
Eye exam	_____	Tdap (Tetnus)	_____
Cholesterol Test	_____	Pneumovax	_____
Sleep study	_____	Pevnar 13	_____
Stool blood test	_____	Influenza (Flu Shot)	_____
Colonoscopy	_____	Zostavax (shingles shot)	_____
Bone Density	_____	Hepatitis B Vaccine	_____
Heart Stress Test	_____	Mammogram	_____
Prostate exam	_____	Pap Smear	_____
PSA Test	_____		
Other	_____		