

PATIENT INFORMATION (PLEASE PRINT)

NAME: _____
(last) (first) (MI)

DATE OF BIRTH: ____/____/____
month day year

SOCIAL SECURITY NUMBER: _____ - _____ - _____

SEX: Male Female

ADDRESS: _____

MARITAL STATUS:
 Single Married Divorced
 Separated Widowed

CITY: _____ STATE: ____ ZIP: _____

ETHNIC GROUP:
 White (not of Hispanic origin)
 Black (not of Hispanic origin)
 Asian or Pacific Islander
 American Indian or Alaskan Native
 Hispanic
 Other

HOME PHONE: (_____) _____

E-MAIL ADDRESS: _____

WHO IS YOUR PHYSICIAN (Primary Care)? _____

EMPLOYMENT INFORMATION

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

WORK PHONE: (_____) _____ ext: _____

OCCUPATION: _____

EMPLOYMENT STATUS: Full-time Retired Active Military Duty Non-employed
 Part-time Self-employed Unknown

GUARANTOR INFORMATION (individual responsible for payment...if SELF, go to next page)

PATIENT'S RELATIONSHIP TO GUARANTOR: Self Child Spouse Other: _____

NAME: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____ HOME: (_____) _____

E-MAIL ADDRESS: _____

GUARANTOR EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

WORK PHONE: (_____) _____ EXT: _____

EMPLOYMENT STATUS:
 Full-Time Part-time
 Retired Self
 Active Military Duty
 Not employed

EMERGENCY/ OTHER CONTACT INFORMATION

PATIENT'S SPOUSE NAME: _____
(last) (first) (MI)

SPOUSE EMPLOYER: _____ PHONE: (_____) _____ EXT _____

PATIENT'S CAREGIVER (if applicable): _____

CAREGIVER PHONE: (_____) _____ EXT _____

EMERGENCY CONTACT NAME (if other than spouse or caregiver): _____

EMERGENCY CONTACT RELATIONSHIP TO PATIENT: Friend Relative Neighbor Caregiver

DAYTIME EMERGENCY PHONE NUMBER: (_____) _____ EXT _____

EVENING EMERGENCY PHONE NUMBER: (_____) _____ EXT _____

PATIENT INSURANCE INFORMATION (please provide a copy of your insurance card(s) to the receptionist)

PRIMARY INSURANCE NAME: _____
(SUCH AS MEDICARE, MEDICAID, OR COMMERCIAL INSURANCE NAME)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ ext: _____

POLICY#, MEDICARE#, OR MEDICAID#: _____ GROUP/CERTIFICATE# _____

INSURED NAME (if different): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO INSURED: Child Spouse Self Other

DATE OF BIRTH: _____
(MONTH) (DAY) (YEAR)

SECONDARY INSURANCE NAME: _____
(SUCH AS MEDICARE, MEDICAID, OR COMMERCIAL INSURANCE NAME)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ ext: _____

POLICY#, MEDICARE#, OR MEDICAID#: _____ GROUP/CERTIFICATE# _____

INSURED NAME (if different): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO INSURED: Child Spouse Self Other

DATE OF BIRTH: _____
(MONTH) (DAY) (YEAR)

PATIENT HISTORY

Name: _____ Date of Birth: _____ Date: _____

DRUG ALLERGIES

CURRENT MEDICATIONS

IMMUNIZATIONS

Approximate Date of Last Injection

- | | |
|--|--|
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Pertussis _____ | <input type="checkbox"/> MMR _____ |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Flu _____ | <input type="checkbox"/> Hepatitis A _____ |
| <input type="checkbox"/> Hepatitis B _____ | |

FAMILY HISTORY

	Father	Mother	Sibling	Child
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death before 65	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

PAST MEDICAL HISTORY (check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Menstrual Dysfunction |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Gout | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Bowel Irregularity | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chest-Pain/Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostatic Disease |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Previous Blood Transfusion | <input type="checkbox"/> Bladder Dysfunction |
| <input type="checkbox"/> Heart Attack | | | |

HABITS (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Smoke (if yes): Packs Daily: _____ | <input type="checkbox"/> Coffee: Cups Daily _____ |
| <input type="checkbox"/> Exercise Routine: _____ | <input type="checkbox"/> Diet: Salt Intake _____ |
| <input type="checkbox"/> Alcohol (if yes): Type/Amount _____ | <input type="checkbox"/> Contact with Blood or Bloody Fluid at Work: _____ |
| <input type="checkbox"/> Snoring _____ | <input type="checkbox"/> Recreational/Street Drug Use (specify) _____ |
| <input type="checkbox"/> Difficulty Falling Asleep _____ | <input type="checkbox"/> HIV Exposure/Risk _____ |

WOMEN ONLY

If you are still menstruating:

Age of onset _____ Regular Irregular

Flow: Heavy Moderate Light

Pain/Cramps with Menses: Yes No

Days of Flow: _____

Length of Cycle: _____

Last Pap Smear: _____

Pregnancy:

of pregnancies _____

of live births _____

of miscarriages _____

Birth Control Methods _____

After Menopause:

Flushing (hot flashes)

Yes No

Breast Exams:

Last mammogram: _____

Monthly self exams:

Yes No