Please complete form in its entirety

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Date of Birth:

Mailing Address: Apt #

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Email Address:	Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Email
Sex: ☐ Male ☐ Female ☐ Transgender	Social Security #:
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other____________________	Employer Name:
Emergency Contact Name and Phone:	Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip:	Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Race (please select):

☐ White ☐ American Indian or Alaska Native ☐ Asian

☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ Other ☐ Decline

Ethnicity (please select one):

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Member ID & Group #:	Member ID & Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Name: ___________________________________ **Allergies** ____

Please list ALL medications you are currently taking, prescribed and or over the counter. Please try and be as specific as possible.

Medication	Dosage	Route	Frequency

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder Problems / Incontinence
Bleeding Problems
Cancer: _______________
Headaches
Crohn's Disease

COPD/ Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease

High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)

Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period	Date: __________	Normal Abnormal
Colonoscopy	Yes/No Date:_____	Normal Abnormal
Mammogram Dexa (Bone Density) Pap	Yes/No Date:_____ Yes/No Date:_____ Yes/No Date:_____	Normal Abnormal Normal Abnormal Normal Abnormal

Other medical problems not listed above:

____

Surgical History: Please list all prior surgeries and approximate dates performed.

______________________________________ ______________________________________

______________________________________ ______________________________________

SOCIAL / CULTURAL HISTORY:

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _______________

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐Never Type:________________Amount/day:__________Number of Years: _________

Alcohol: ☐Current ☐Past ☐Never Drinks/week: __________

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: ____

Are you sexually active? ☐Yes ☐No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

____

____

FAMILY HISTORY:

FATHER: Living: Age _____________ Deceased: Age _____________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: ____________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

MOTHER: Living: Age _____________ Deceased: Age _____________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: ____________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

SIBLINGS:

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____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

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Patient Signature ______________________________