Progressive Medical Associates, PLLC
PATIENT REGISTRATION INFORMATION

PATIENT NAME: _____ ❑ M ❑ F
(Last) *(First)* *(Middle)*

NAME YOU PREFER TO BE CALLED: _____ BIRTHDATE: ___/_____/_____ SSN: _____

ADDRESS: _____CITY: _____ STATE: ____ ZIP _____

EMAIL ADDRESS: _____

CELL PHONE: _____ HOME PHONE: _____

MARITAL STATUS: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widow PREFERRED LANGUAGE: _____

RACE: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Pacific Islander
❑ White Hispanic or Latino ❑ Black Hispanic or Latino

DO YOU HAVE ANY SPECIAL COMMUNICATION REQUIREMENTS (hearing, vision, trouble understanding)? ❑Yes ❑No

EMERGENCY CONTACT PERSON _____ RELATIONSHIP _____

ADDRESS: _____ TELEPHONE: _____

PREFERRED LOCAL PHARMACY: _____ Address: _____

MAIL ORDER PHARMACY: (If you have one): _____

PRIMARY INSURANCE _____ NAME OF POLICY HOLDER _____
INSURED'S ID # _____GROUP # _____ BIRTHDATE OF POLICYHOLDER: _____
SECONDARY INSURANCE _____ NAME OF POLICY HOLDER _____
INSURED'S ID # _____ GROUP # _____ BIRTHDATE OF POLICYHOLDER: _____

WILL THE PATIENT BE THE FINANCIALLY RESPONSIBLE PARTY: ❑Yes ❑No

IF NO, WHO WILL BE THE FINANCIALLY RESPONSIBLE PARTY? _____

RELATIONSHIP TO PATIENT: _____ SSN # :_____ PHONE_____

ADDRESS _____

Are you interested in joining Dr. Stacy Le's personalized (concierge) healthcare service or would you like more information?
❑ Yes ❑ No

I understand my insurance coverage is a relationship between my insurance company and myself, and Progressive Medical is unable to quote or guarantee my benefits. I agree to accept financial responsibility for charges incurred that are not reimbursed by my insurance company. I understand that I may be billed for "no-shows" or late cancellations.

PRINTED NAME of PATIENT: _____ DATE: _____

SIGNATURE (*Patient or financially responsible party)*:

_____
(If patient is under the age of 18, must be signed by financially responsible party)

Progressive Medical Associates, PLLC

NEW PATIENT HEALTH QUESTIONNAIRE

Room: ____

NAME: _____ DATE: _____

What is the reason for your visit today *(Check all that apply)*:

☐ Get established with the practice ☐ Annual Wellness ☐ Sick/Medical Concerns: _____

Please list any current or past medical problems along with the approximate year they occurred: _____

_____

_____

Please list any hospitalizations and the year they occurred, including surgeries: _____

_____

_____

Please list any other physicians you are currently seeing:

Physician ***Location*** ***Reason***

_____

_____

_____

MEDICATIONS: Please list the medications you are taking (including over-the-counter, vitamins, herbs & birth control):

Medication ***Dosage*** ***How often you take it***

ALLERGIES: Do you have any allergies to any medications? ❑Yes ❑No

Medication ***Reaction***

FAMILY HISTORY:

	Living	Deceased	Medical conditions and the age that they occurred
Father	____	____	_____
Mother	____	____	_____
Siblings	____	____	_____
Maternal Grandmother	____	____	_____
Maternal Grandfather	____	____	_____
Paternal Grandmother	____	____	_____
Paternal Grandfather	____	____	_____

Is there anyone else in the family that has suffered from high blood pressure, diabetes, high cholesterol, heart disease, prostate cancer, breast cancer, colon cancer, alcoholism, mental health issues, or anything else you feel is important?

_____

_____

SOCIAL HISTORY:

Occupation: _____ Highest Level of Education/Degree_____
Spouse's occupation?_____ Highest Level of Education/Degree _____
Who lives at home with you? _____ # of children & ages: _____
Sexual orientation ❑Heterosexual ❑Homosexual ❑Bisexual
Religion: _____ Do you have any religious/spiritual beliefs we need to know about for your healthcare? _____
Are you currently a smoker? ❑Yes ❑No If yes, how much do you smoke daily? _____
If you do not currently smoke, have you ever been a cigarette, pipe, or cigar smoker? ❑Yes ❑No
If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____ Year Quit _____
Any exposure to secondhand smoke (others smoking around you) either currently or in the past? ❑Yes ❑No
If yes, please explain: _____
Do you currently use recreational drugs (like marijuana, etc)? ❑Yes ❑No
Do you wear a seatbelt? ❑Yes ❑No ❑Occasionally
Do you exercise regularly? ❑Yes ❑No If yes, what do you do for exercise and how often? _____
Please describe your diet? _____
What do you and your partner use for contraception (*if applicable*): _____
Would you like to be tested for, STDs or HIV? ❑Yes ❑No

HEALTHCARE WISHES:

Do you already have a healthcare proxy or living will? ❑Yes ❑No Are you willing to be an organ donor? ❑Yes ❑No
Most healthy patients would like to be treated aggressively (such as CPR, respirator, ICU, etc) if they had a potentially curable condition. If you had a condition that had no chance of recovery, would you wish to remain on life support? ❑Yes ❑No ❑Not Sure

If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident)*, whom would you like us to ask about what your wishes would be? Please name one person and one alternate.
Name: _____Phone No: _____Relationship to You: _____
Name: _____Phone No: _____Relationship to You: _____

HEALTH MAINTENANCE:

Have you ever had:	***Yes***	***No***	***If Yes, approximately when was the last time:***
Physical Exam	___	___	_____
Cholesterol Checked	___	___	_____
Colonoscopy/Sigmoidoscopy/Cologuard	___	___	_____
Flu Shot	___	___	_____
Covid-19 Vaccine	___	___	_____
Pneumonia Shot	___	___	_____
Tetanus Shot	___	___	_____
MMR Shot (*Measles/Mumps/Rubella)*	___	___	_____
Hepatitis Shot	___	___	_____
Skin Test for TB (*PPD*)	___	___	_____
HIV Screening	___	___	_____
Hepatitis C Screening	___	___	_____
Eye Exam	___	___	_____
Do you see a dentist at least once a year?	___	____	_____

Female Patients:	***Yes***	***No***	***Date of Last***
Physician Breast Exam	___	___	_____
Pap Smear	___	___	_____
Mammogram	___	___	_____
Bone Density	____	____	_____

Male Patients:	***Yes***	***No***	***Date of Last***
PSA Blood Test	___	___	_____

Name: _____ **Date:** _____

ANNUAL HEALTH SCREENINGS:

PHQ-9 **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** ***(Please ✓ the appropriate box)***	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off <u>any</u> problems listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(Please **circle** your answer)*	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: _____ Dx: _____

AUDIT-C Please **circle** your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____