Heroes Healthcare
Primary Care

PATIENT DEMOGRAPHICS

PATIENT

Patient: _____ DOB: _____ SS#: _____
First Name Middle Initial Last Name

Marital Status: ☐Single ☐Married ☐Divorced

Gender Identity: ☐Male ☐Female ☐ Other Gender Category

Race: ☐ Alaska Native or Native American ☐ Asian ☐ African American ☐ Caucasian

☐ Native Hawaiian or other Pacific Islander ☐ Other: _____

Ethnicity: ☐ Not Hispanic or Latino(a) ☐ Hispanic or Latino(a)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Preferred method of communication: ☐ Postal Mail ☐ Patient Portal ☐ Cell Phone ☐ Home Phone

NEXT OF KIN

Name: _____ DOB: _____
First Name Middle Initial Last Name

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

GUARANTOR

Name: _____ DOB: _____
First Name Middle Initial Last Name

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

☐Check box if Guarantor is same as patient

PHARMACY: _____ Location: _____ Phone Number: _____

_____ _____
Signature of Patient/Guardian Date

CONSENT FOR TREATMENT and FINANCIAL RESPONSIBILITY

Patient Name: _____ D.O.B: _____

CONSENT FOR MEDICAL TREATMENT: I understand, that Heroes Healthcare Primary Care does not have a physician regularly onsite and does not always staff with a physician; services may be performed by a nurse practitioner or physician assistant. I hereby request admission to this facility and authorize my attending physician, nurse practitioner, or physician assistant to order and/or administer any treatment, procedures, tests, examinations, or other services of a routine medical, or surgical nature, or health or physical condition.

I authorize Heroes Healthcare Primary Care, its employees and agents to perform nursing care, diagnostic procedures, and medical treatment requested by my attending physician, nurse practitioner, or physician assistant. I understand this may include, but is not limited to diagnostic x-ray procedures, vein punctures for lab, intravenous procedures and clinical digital images for substantiation or clarification. All digital images will be considered part of the confidential record and will be treated as confidential information related to the diagnosis, treatment or prognosis of the patient. I further authorize Heroes Healthcare Primary Care to release my medical records to entities that utilize this information for peer review, quality management, trend and outcome studies or other educational or research purposes. I authorize Heroes Healthcare Primary Care to transmit by postal mail, electronically, or via facsimile any medical data pertaining to my care.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me to the result of treatments or examinations at Heroes Healthcare Primary Care.

FINANCIAL RESPONSIBILITY POLICY: By signing below, I understand that Heroes Healthcare Primary Care does not participate in any health insurance plan and that I am solely responsible for paying for my visit, including any labs or tests that are performed during my visit. I further understand that payment for services rendered are due at the end of my visit, unless I am part of the direct primary care membership program, then I am responsible for certain costs as indicated within my membership agreement.

I understand that failure to pay as agreed above may result in the account being placed with a collection agency. I also understand that I will be responsible for any agency fees that may result from this action.

Please sign below indicating that you are fully aware of our Consent for Treatment, and Financial Policies and you are responsible to pay any balance due at the time services are rendered.

_____ _____

Patient/Guardian Signature Date

_____

Witness

HEALTH INSURANCE ASSIGNMENT OF BENEFITS AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with the insurance company information provided to Heroes Healthcare Primary Care. I authorize Heroes Healthcare Primary Care to release any medical information about me or my dependent that is/was a patient of Heroes Healthcare Primary Care to the insurance company identified below and its agents for the purpose of determining benefits or payment of benefits for today's office visit. I also request that payment of benefits be made on my behalf directly to Heroes Healthcare Primary Care from my health insurance carrier identified below.

I further understand that I am financially responsible for all services provided by Heroes Healthcare Primary Care that are not covered by my insurance carrier.

Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Effective Date of Coverage: _____

Primary Member Name: _____

Primary Member Date of Birth: _____

_____ _____

Signature of Patient/Guardian **Date**

AUTHORIZATION FOR THE USE OF ELECTRONIC COMMUNICATIONS

Heroes Healthcare, PLLC dba Heroes Healthcare Primary Care utilizes various forms of electronic communication such as voicemail, text messages, and email messages to schedule or change appointments, provide reminders to patients of upcoming appointments, provide marketing information, or provide electronic receipts of monthly membership payments if on the monthly membership plan.

_____ I want to receive text messages, voicemails, or emails for the purpose of health information, appointment reminders, or electronic receipts.

_____ I DO NOT want to receive text messages, voicemails, or emails for the purpose of health information, appointment reminders, or electronic receipts.

This authorization will remain in effect until canceled by you, the patient, or the guardian. This authorization can be canceled at any time in writing or by completing a new "Authorization for the use of Electronic Communications" form.

_____ _____

Signature of Patient/Guardian **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of
PATIENT'S NAME (PRINT)

Heroes Healthcare Primary Care Notice of Privacy Practice's.

_____ _____
Signature of Patient/Guardian/Responsible Party **Date**

♦OFFICE USE ONLY♦

Heroes Healthcare Primary Care was unable to obtain acknowledgement because:

- ☐ **Emergency**
- ☐ **Patient Non-Responsive**
- ☐ **Patient Sedated**
- ☐ **Patient Confused/Disoriented**
- ☐ **Patient Refused – Reason** _____
- ☐ **Other** _____

_____ _____
Staff Signature **Date**

Heroes Healthcare
Primary Care

MEDICAL & SURGICAL HISTORY

PAST MEDICAL HISTORY

- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Herpes Zoster (Shingles)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves Disease
- ☐ Migraine Headaches
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Vitamin D Deficiency
- ☐ History of Chickenpox
- ☐ History of Deep Vein Thrombosis (DVT)
- ☐ History of Measles
- ☐ History of Mumps
- ☐ History of Myocardial Infarction (Heart Attack)
- ☐ History of Pneumonia
- ☐ History of Pulmonary Embolism (PE)
- ☐ History of Rubella
- ☐ History of Stroke
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

SURGICAL HISTORY

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Adenoidectomy
- ☐ Amputation (location: _____)
- ☐ Angioplasty (# of Stents: _____)
- ☐ Ankle Surgery (☐ R / ☐ L / ☐ B)
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bladder Lift
- ☐ Breast Augmentation
- ☐ Breast Reduction
- ☐ CABG (# of vessels: _____)
- ☐ Carpal Tunnel Surgery (☐ R / ☐ L / ☐ B)
- ☐ Cataract Surgery (☐ R / ☐ L / ☐ B)
- ☐ Cholecystectomy (Gallbladder removed)
- ☐ C-Section (how many: _____)
- ☐ Gastric Bypass
- ☐ Gastric Sleeve
- ☐ Hernia (type: _____)
- ☐ Hip Surgery(☐ R / ☐ L / ☐ B)
- ☐ Hysterectomy – Complete
- ☐ Hysterectomy – Partial
- ☐ Knee Surgery (☐ R / ☐ L / ☐ B)
- ☐ Lasik (☐ R / ☐ L / ☐ B)
- ☐ Liposuction (location: _____)
- ☐ Mastectomy (☐ R / ☐ L / ☐ B)
- ☐ Neck Surgery
- ☐ Oophorectomy (☐ R / ☐ L / ☐ B)
- ☐ Shoulder Surgery (☐ R / ☐ L / ☐ B)
- ☐ Sinus Surgery
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tooth/Teeth Extraction
- ☐ Transurethral Resection of Prostate
- ☐ Tubal Ligation
- ☐ Tympanoplasty and Tubes
- ☐ Vasectomy
- ☐ Wrist Surgery (☐ R / ☐ L / ☐ B)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Heroes Healthcare
Primary Care

FAMILY MEDICAL HISTORY

FATHER

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

MOTHER

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Heroes Healthcare
Primary Care

FAMILY MEDICAL HISTORY

SIBLING (☐ brother ☐ sister)

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

SIBLING (☐ brother ☐ sister)

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Heroes Healthcare
Primary Care

FAMILY MEDICAL HISTORY

MATERNAL GRANDFATHER

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

MATERNAL GRANDMOTHER

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Heroes Healthcare
Primary Care

FAMILY MEDICAL HISTORY

PATERNAL GRANDFATHER

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

PATERNAL GRANDMOTHER

- ☐ Deceased
- ☐ UNKOWN History
- ☐ Alzheimer's Disease
- ☐ Anemia (type _____)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer (type _____)
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia (type _____)
- ☐ Depression
- ☐ Diabetes Mellitus (Type 1)
- ☐ Diabetes Mellitus (Type 2)
- ☐ Eczema
- ☐ Emphysema
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Headaches (Tension, Cluster)
- ☐ Heart Murmur
- ☐ Huntington's Dementia
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypertriglyceridemia (High Triglycerides)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Graves' Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

IMMUNIZATION QUESTIONNAIRE

Have you ever had any of the following vaccines?

☐ Annual Influenza Vaccine

If known, date of vaccine or most recent update _____

☐ Tetanus/diphtheria (Td) or Tetanus/diphtheria/pertussis (Tdap) Vaccine within the last 10 years

If known, date of vaccine or most recent update _____

☐ COVID-19 Vaccine

If known, date of vaccine or most recent update _____

☐ Measles/Mumps/Rubella Vaccine

If known, date of vaccine or most recent update _____

☐ Varicella (Chickenpox) Vaccine

If known, date of vaccine or most recent update _____

☐ Herpes Zoster (Shingles) Vaccine

If known, date of vaccine or most recent update _____

☐ Pneumonia Vaccine

If known, date of vaccine or most recent update _____

☐ Human Papillomavirus (HPV) Vaccine

If known, date of vaccine or most recent update _____

☐ Hepatitis A Vaccine

If known, date of vaccine or most recent update _____

☐ Hepatitis B Vaccine

If known, date of vaccine or most recent update _____

☐ Meningococcal (Meningitis) Vaccine

If known, date of vaccine or most recent update _____

Heroes Healthcare
Primary Care

SMOKING/ALCOHOL/RECREATIONAL STREET DRUGS

CURRENT TOBACCO USE:

- ☐ Non-Smoker
- ☐ Former Smoker – quit _____(MM/YYYY or YYYY)
- ☐ Light cigarette smoker (1 to 9 cigarettes a day)
- ☐ Moderate cigarette smoker (10 to 19 cigarettes a day)
- ☐ Heavy cigarette smoker (20 to 39 cigarettes a day)
- ☐ Very heavy cigarette smoker (40+ cigarettes a day)
- ☐ Electronic cigarette smoker (Vaping)
- ☐ Cigar Smoker
- ☐ Pipe Smoker
- ☐ Chew tobacco
- ☐ Use Snuff (dip)

CURRENT ALCOHOL USE:

How often do you have a drink containing alcohol?

- ☐ Never
- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

- ☐ 0
- ☐ 1 to 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

How often do you have 6 or more drinks on one (1) occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost every day

RECREATIONAL STREET DRUG USE

YES ☐ NO ☐

IF YES, what kind of recreational street drugs do you use?

- ☐ Marijuana
- ☐ Methamphetamines
- ☐ Ecstasy
- ☐ Cocaine
- ☐ Heroin
- ☐ PCP
- ☐ GHB
- ☐ Other: _____

Patient Name: _____

Patient DOB: _____

Medication List

(list all prescribed and over-the-counter medications, vitamins, or supplements that you are taking)

Medication Name	Dose	How do you Take	This is taken for	Prescribed By
i.e. – Lisinopril	5 mg	1 tablet daily	High blood pressure	Dr. John Doe

ALLERGIES: Are you allergic to any medications, foods, or pollens? If So, please list here: _____

_____

_____

The use of this form does not constitute a provider-patient relationship exists between the above name individual and Heroes Healthcare Primary Care provider. Permission to reproduce and use this form to keep record current medications is granted.

Rev. 07/02/2024