PATIENT INFORMATION

****PLEASE ENTER ALL INFORMATION AS IT APPEARS ON INSURANCE****

____ **Preferred Name:** ____________________

Last Name **First Name** **MI**

Mailing Address: ________________________________ City: ________________ Zip: __________

Best # to be reached: (_______)-________-___________ 2nd #: **(_______)-________-___________**

DOB: ______/______/________ **Social Security #:** _______-______-________ Email: ______________________________

Employer:____ Work #: (______)-_______-_________

SEX: M F **MARITAL STATUS:** Married Single Divorced Separated Widowed

RACE: Black or African American White Hispanic Other: ____________________

ETHNICITY: Hispanic or Latino/Spanish Not Hispanic or Latino Other: ____________________

Primary (PCP) Doctor: ____________________________ Referring Doctor: ____________________________

PHARMACY INFORMATION:

PHARMACY: ____________________________CITY:____________________ PHONE #: (______)-_______-_________

EMERGENCY CONTACT:

Name: ________________________________Relation: ________________ PHONE #: (______)-_______-_________

****GUARANTOR INFORMATION** (*For Minors Only*)

Parent's Name: ____ DOB: ______/______/_______

Social Security #: _______-______-_______ *Parent Employer: ______________________________________

INSURANCE INFORMATION

Primary: ______________________________ Policy #: __________________________ Grp: __________

Secondary: ____________________________ Policy #: __________________________ Grp: __________

*************If policyholder/responsible party are different from the patient, please answer the questions below*************

Name: ______________________________ DOB: ______________ Social Security #: __________________

Address: ____ Relationship to patient: __________________

PATIENT QUESTIONNAIRE
CHIEF COMPLAINT/HISTORY OF ILLNESS

Reason for today's visit: ______________________________

How long have you had this problem? ______________________________

What makes it better? ______________________________

What makes it worse? ______________________________

What other symptoms are you having? ______________________________

MEDICAL HISTORY *(Please check any illness that you have)*

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Cancer
- ☐ Chronic Neck/Back Pain
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Heart Attack
- ☐ Heart Failure (CHF)
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Schizophrenia
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other________________

FOR CHILDREN ONLY *(Please answer for children under 18 years old)*

Type of Birth:

- ☐ Vaginal Delivery
- ☐ C-Section
- ☐ Full Term (__________weeks)
- ☐ Premature (__________weeks)

Any Complications at Birth? **YES** **NO**

PAST SURGICAL HISTORY *(Please check any surgeries that you have had.)*

- ☐ Appendix Removal
- ☐ Low Back Surgery
- ☐ Brain Surgery
- ☐ Carotid Artery Surgery
- ☐ Colon Removal
- ☐ Coronary Angioplasty/ Stent
- ☐ Ear Tubes
- ☐ Gallbladder
- ☐ Heart Bypass/Valve
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Lung Surgery
- ☐ Mastectomy
- ☐ Neck Spine Surgery
- ☐ Organ Transplant
- ☐ Pacemaker/Defibrillator
- ☐ Prostate Removal
- ☐ Repair of Broken Bones
- ☐ Sinus Surgery
- ☐ Skin Cancer Removal
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Vascular Bypass
- ☐ Other ________________

FAMILY HISTORY *(Check all illnesses that run in your family.)*

- ☐ Alcoholism
- ☐ Anesthesia Reaction
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Psychiatric Illness
- ☐ Sickle Cell Anemia
- ☐ Stroke

SOCIAL HISTORY *(Circle One)*

Occupation: ______________________________ **Full Time** **Part Time** **Retired** **Disabled** **Unemployed**

How much alcohol do you drink each day? ______________________________

Have you ever used tobacco? **YES** **NO** Do you currently use any tobacco products? **YES** **NO**

How much & for how long? _______ per/day for _______ yrs.

Did you Quit? **YES** **NO** How long ago? ________________________

What kind of tobacco do you use? **Cigarettes** **Cigar** **Pipe** **Chewing Tobacco** **Skoal**

Are you exposed to second hand smoke? **YES** **NO**

Do you have any drug addictions? **YES** **NO**

Are you up to date on your immunizations? **YES** **NO**

Patient Name: ____

PATIENT MEDICATION RECORD

☐ **PATIENT TAKES NO ROUTINE MEDICATIONS** *(Please List Any PRN or "As Needed" Medications below)*

DATE	PRESCRIPTION	DOSAGE	FREQUENCY

DRUG ALLERGIES (PLEASE LIST):

☐ NO KNOWN DRUG ALLERGIES

____

____

MARK ANY OF THESE BLOOD THINNERS THAT YOU TAKE:

☐ ASPIRIN
☐ LOVENOX
☐ GOODY POWDERS
☐ VITAMIN E
☐ PLAVIX
☐ COUMADIN
☐ XARELTO
☐ HEPARIN
☐ NSAIDS (MOTRIN/ ALEVE/ IBUPROFEN/ ADVIL/ NAPROXEN)

ARE YOU ALLERGIC TO?

☐ MEDICAL TAPE
☐ IODINE
☐ LATEX

Patient Name: ____

REVIEW OF SYSTEMS

(Select all symptoms that apply)

CONSTITUTIONAL: ☐ Chills ☐ Excessive Fatigue ☐ Fever ☐ Weight Gain __________ lbs in the past _________ weeks. ☐ Weight Loss ___________ lbs in the past _________ weeks.	**EYES:** ☐ Double Vision ☐ Drainage from Eyes ☐ Glasses/Contacts ☐ Blindness
ALLERGY/IMMUNOLOGY: ☐ Seasonal Allergies ☐ Allergy tested in the past ☐ Blood transfusion in the past	**RESPIRATORY:** ☐ Cough ☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing
CARDIOVASCULAR: ☐ Chest pain ☐ Edema of the legs ☐ Trouble breathing while lying flat ☐ Palpitations	**NEUROLOGICAL:** ☐ Fainting spells ☐ Headaches ☐ Paralysis of an arm or leg ☐ Seizures ☐ Tremor
GASTROINTESTINAL: ☐ Abdominal pain ☐ Heartburn ☐ Nausea	**GENITOURINARY:** ☐ Blood in Urine ☐ Bed wetting
MUSCULOSKELETAL: ☐ Joint pain ☐ Joint stiffness ☐ Muscle pain	**SKIN:** ☐ Growths on the skin ☐ Rash ☐ Non-healing wounds
HEMATOLOGIC: ☐ Easy bleeding ☐ Easy bruising ☐ Lymph nodes swelling (neck, groin area, or underarm)	**PSYCHIATRIC:** ☐ Clinical depression ☐ Nervousness/Anxiety ☐ Increased stress level ☐ Other psychiatric disorder:_________________________

I confirm the above information is true and correct.

____ ______________________

Patient Signature Date