PATIENT INFORMATION & MEDICAL HISTORY

Full Name: _____ **Date:** _____

DOB: _____ **Age:** _____ **Birth Sex:** _____

Social Security Number: _____

Address: _____

Phone: _____ **Email:** _____

Reason for Today's Visit: _____

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language: _____

Emergency Contact Information:

Name: _____

Phone Number: _____ **Relationship:** _____

Pharmacy & Location: _____

Childhood Illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:

☐ Tetanus or TdaP	☐ Pneumonia
☐ Hepatitis	☐ Chickenpox
☐ Influenza	☐ MMR (Measles,mumps,rubella)
☐ HPV	☐ Covid
☐ Shingles	

Previous Surgeries:

Type	Year	Complications

Health Maintenance Screening History:

Type	Date	Facility/Place	Abnormal Result
Cholesterol			YES NO
Colonoscopy/Sigmoid			YES NO
Mammogram			YES NO
Pap Smear			YES NO
Dexa/Bone Density			YES NO
PSA			YES NO

ALLERGIES: ☐ NO ALLERGIES

ALLERGY/ALLERGEN	REACTION

MEDICATIONS:

Medication	Strength	Frequency

Social History:

Smoking/Tobacco Use: ☐ Current ☐ Former ☐ Never # a day _____ # of years ____

Alcohol Use: ☐ Current ☐ Former ☐ Never Drinks/day _____ Drinks/Month_____

Drug Use: ☐ Current ☐ Former ☐ Never Type: _____

Sexually Active: ☐ Yes ☐ No Last Menstrual Period: _____

Cultural Concerns/Beliefs related to care ☐ Yes ☐ No Type:_____

MEDICAL HISTORY

Check All That Apply:	YES	NO	Check All That Apply:	YES	NO
ADHD			Hepatitis		
Allergies, Seasonal			High Blood Pressure		
Anemia			High Cholesterol		
Anxiety			History of DVT/PE		
Arthritis			HIV/AIDS		
Asthma			Irritable Bowel Syndrome		
Bipolar			Kidney Disease		
Bladder Problems			Neuropathy		
Bleeding/Clotting Disorder			Osteopenia/Osteoporosis		
Cancer			Parkinson's Disease		
Cataracts			Peripheral Vascular Disease		
Chest Pain			Psoriasis		
COPD/Emphysema			Seizure Disorder		
Dementia			Sexual Dysfunction		
Depression			Sleep Apnea		
Diabetes			STI/STD		
GERD			Stroke		
Glaucoma			Thyroid Disorder		
Headaches			Weight Concerns		
Heart Disease Disease/Conditions			Other:		

FAMILY HISTORY

☐ **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

Check All That Apply	Mother	Father	Sibling	Child	Maternal Grandparents	Paternal Grandparents
Alcohol/Drug Abuse						
Cancer Type:						
Mental Health						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Dementia						
Parkinson's						

WOMEN'S HEALTH:

Age at onset of menstruation: _____ Date of Last Menstruation:_____

Number of Pregnancies: _____ Number of Live Births: _____

Currently Pregnant: _____ Date of Last Pap: _____

MEN'S HEALTH:

Testicle Pain or Swelling: _____ Date of Last Prostate Exam: _____

Blood in your urine: _____ Discharge From Penis: _____

Difficulty with ejaculation: _____

Consent to Treat

I have the legal right to consent to medical and surgical care/treatment for this patient. I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that the clinic and its licensed medical providers and designees consider necessary. I understand that no warranty or guarantee has been or will be made as the result or cure from treatment. I understand that by signing this form, I am giving permission to Incredible Family Health & Wellness and its providers to administer treatment to this patient for as long as they are under the care of Incredible Family Health & Wellness or until I withdraw my consent.

Electronic Prescriptions (E-Prescribing)

I authorize E-prescribing for prescriptions. This allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a provider/patient relationship exists.

Acknowledgements

I acknowledge that administrative data, demographics information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and nongovernmental reporting, and comparisons with other providers. In some instances, performance data is aggregated and reported per physician. In every instance, we make every reasonable effort to maintain patient and provider anonymity.

Imaging

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs of films may be made part of the medical record and/or used for internal purposes such as performance improvement or education.

Notice of Privacy Policies

I have had the opportunity to review the "Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

Patients Name: _____

Signature: _____

Date: _____