Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you a junior, senior \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male or Female DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS IF DIFFERENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAIDEN LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER NAMES USED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHERS FULL NAME TO INCLUDE MAIDEN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRIVERS LICENSE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HISPANIC OR LATINO: YES OR NO ETHNICITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RACE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

Relationship to Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_secondary number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL INFORMATION**:

WHO IS FINANCIALLY RESPONSIBLE FOR YOU? (CHECK WHAT APPLIES)

* SELF
* SAME AS EMERGENCY CONTACT
* OTHER

METHOD OF PAYMENT: WHAT WILL BE YOUR METHOD OF PAYMENT?

* SELFPAY
* INSURANCE

**ADDITIONAL INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY: INTERMEDIATE FAMILY ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relationship** | **Alive or deceased** | **Illnesses** | **Other information** |  |
| **MOTHER** |  |  |  |  |
| **FATHER** |  |  |  |  |
| **BROTHER 1** |  |  |  |  |
| **BROTHER 2** |  |  |  |  |
| **SISTER 1** |  |  |  |  |
| **SISTER 2** |  |  |  |  |
| **GRANDMOTHER (MATERNAL)** |  |  |  |  |
| **GRANDMOTHER (PATERNAL)** |  |  |  |  |
| **GRANDFATHER (MATERNAL)** |  |  |  |  |
| **GRANDFATHER (PATERNAL)** |  |  |  |  |

**Surgery**

|  |  |  |
| --- | --- | --- |
| **PROCEDURE** | **ADMISSION DATES** | **REASON** |
|  |  |  |
|  |  |  |

**PAST MEDICAL HISTORY:**

**PLEASE CHECK ALL THAT APPLY:**

|  |  |  |
| --- | --- | --- |
| * TRAUMA * Dementia * Alzheimer’s * Blindness * Cataracts * Glaucoma * Wears glasses or contacts * Diabetic Peripheral Neuropathy * Hepatitis * Hiatal Hernia * Asthma * Bronchitis * COPD * Nephrolithiasis * Other kidney disease * UTIs * Prostatitis * STDs * Hysterectomy * Prostate Cancer * HIV * STDs * TB disease A fib * CHF * Suicidal Attempts * Panic Attacks | * Hearing aids * Ringing in the ears * Hearing loss * Meniere’s Disease * Dentures * Tonsilitis * Epilepsy * Seizures * Severe Headaches * Migraines * Stroke * TIA * Moles * Psoriasis * Eczema * DM II * DM I * Gestational Diabetes * Breast Cancer * Endometriosis * Chicken Pocks * Mumps * Measles Bipolar Disorder * Hallucinations * Depression * Anxiety * Schizophrenia | * Allergic Rhinitis * Seasonal allergies * Sinus infections * Anemia * Cancer * Bruising * Bleeding tendencies * GERD * Gallbladder Disease * Heartburn * Ulcer * OSA * Goiter * Hyperlipidemia * Hypothyroidism * Hyperthyroidism * Arthritis * Gout * Back Pain * Restless leg Syndrome * Lupus * Angina * DVT (blood clots) * Dysrhythmia * Hypertension * Murmur * MI (heart attack) |

Any Not Listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:**

|  |  |  |
| --- | --- | --- |
| **NAME OF ALLERGY** | **WHAT DOES IT CAUSE** | **COMMENTS** |
|  |  |  |
|  |  |  |

**SOCIAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_ Please check here if you have traveled domestically or internationally in the past 6 months.**

**OBGYN HISTORY:**

Age onset on menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age onset of Menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

|  |  |  |
| --- | --- | --- |
| * History of Hormone replacement therapy * History of fertility drugs | * History of abnormal pap smear * History of irregular menses | * History of cervical biopsy * History of painful intercourse |
| Total pregnancies \_\_\_\_\_\_\_\_\_  Total Living: \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_ | Full term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pre-term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| NAME AND STRENGTH | HOW OFTEN TAKEN | 30- or 90-DAY PRESCRIPTION |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

MEDICATIONS:

**SOCIAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| **TOBACCO**   * **Current everyday smoker** * **Current someday smoker** * **Former smoker** * **Heavy tobacco smoker** * **Light tobacco smoker** * **Never smoked** * **Current smoking status unknown** * **Unknown if ever smoked** * **Other forms of tobacco used please list:** | **ALCOHOL**   * **Do not drink** * **Drink daily** * **Frequently drink** * **History of alcoholism** * **Occasional drink**   **Please list amount and frequency:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DRUG USE**   * **History of drug use** * **Illicit drug use** * **Never any drug use**   **Please list if any type and for how long and how often:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

PLEASE LIST ANY OTHER PERTINENT INFORMATION YOU FEEL IS IMPORTANT FOR US TO KNOW. TO INCLUDE OTHER PROVIDERS THAT YOU CURRENTLY SEE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT PATIENT NAME OR REPRESENTATIVE OR GUARDIAN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

062022