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 |
|  |  |  |
|  |  |  |
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|  |  |  |

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