**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: Male Female**

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

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREFFERED PHARMACY NAME & LOCATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREFFERED LAB:** QUEST TRICORE

**PRIMARY PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPECIALISTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE**

**GoPrivateMD will not bill your insurance. Insurance is used for labs, prescriptions and other tests that may be necessary. We can make a copy of you card instead of entering information.**

**Name of Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance company address and telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VITALS**

**To be completed by GPMD Staff**

|  |  |
| --- | --- |
| **Height** |  |
| **Weight** |  |
| **Temperature** |  |
| **Blood Pressure** |  |
| **Pulse** |  |
| **Respiratory Rate** |  |
| **O2 Saturation** |  |

|  |  |
| --- | --- |
|  |  |

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT ISSUES/PROBLEMS**

**CURRENT MEDICATIONS**

**Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements.**

**PAST MEDICAL HISTORY**

**Do you now or have you ever had:**

🞎 Diabetes 🞎 Heart murmur 🞎 Crohn’s disease

🞎 High blood pressure 🞎 Pneumonia 🞎 Colitis

🞎 High cholesterol 🞎 Asthma 🞎 Anemia

🞎 Hypothyroidism 🞎 Emphysema 🞎 Jaundice

🞎 Goiter 🞎 Stroke 🞎 Hepatitis

🞎 Cancer (type) 🞎 Epilepsy 🞎 Stomach/peptic ulcer

🞎 Leukemia 🞎 Cataracts 🞎 Rheumatic fever

🞎 Psoriasis 🞎 Kidney disease 🞎 Tuberculosis

🞎 Angina 🞎 Kidney stones 🞎 HIV/AIDS

🞎 Heart Problems

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGICAL HISTORY**

**List all surgeries and dates:**

**PRIOR HOSPITALIZATIONS**

**List reason for hospitalization and dates:**

**ALLERGIES**

**Drug Allergies:**

**Food Allergies:**

**Environmental Allergies:**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SYSTEMS REVIEW**

**GENERAL STOMACH & INTESTINES PSYCHIATRIC**

🞎 Recent weight gain: how much 🞎 Nausea 🞎 Depression

🞎 Recent weight loss: how much 🞎 Heartburn 🞎 Excessive worries

🞎 Fatigue 🞎 Stomach pain 🞎 Difficulty falling asleep

🞎 Weakness 🞎 Vomiting 🞎 Difficulty staying asleep

🞎 Fever 🞎 Yellow jaundice 🞎 Difficulties with sexual arousal

🞎 Night sweats 🞎 increasing constipation 🞎 Poor appetite

🞎Persistent diarrhea 🞎 Food cravings

**MUSCLE/JOINT/BONES** 🞎Blood in stools 🞎 Frequent crying

🞎 Numbness 🞎 Black stools 🞎 Sensitivity

🞎 Joint pain 🞎 Thoughts of suicide/attempts

🞎 Muscle weakness **SKIN** 🞎 Stress

🞎 Joint swelling 🞎Redness 🞎 Irritability

Where? 🞎 Rash 🞎 Poor concentration

🞎 Nodules/bumps 🞎 Racing thoughts

**EARS** 🞎Hair Loss 🞎 Guilty thoughts

🞎 Ringing in ears 🞎 Color changes of hands or feet 🞎 Paranoia

🞎 Loss of hearing 🞎 Mood swings

**BLOOD** 🞎 Anxiety

**EYES** 🞎Anemia 🞎 Risky behavior

🞎 Pain 🞎 Clots

🞎 Redness

🞎 Loss of vision **KIDNEY/URINE/BLADDER**

🞎 Double or blurred vision 🞎 Frequent or painful urination

🞎 Dryness 🞎 Blood in urine

**THROAT WOMEN ONLY:**

🞎 Frequent sore throats 🞎 Abnormal Pap smear

🞎 Hoarseness 🞎 Irregular periods

🞎 Difficulty in swallowing 🞎 Bleeding between periods

🞎 Pain in jaw 🞎 PMS

**HEART AND LUNGS**

🞎 Chest pain

🞎 Palpitations

🞎 Shortness of breath

🞏 Fainting

🞏 Swollen legs or feet

🞏 Cough

**NERVOUS SYSTEM**

🞎 Headaches

🞎 Dizziness

🞎 Fainting or loss of consciousness

🞎 Numbness or tingling

🞎 Memory loss

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSONAL HISTORY**

**Where were you born and raised?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Highest level of education? 󠄀**❑High school ❑ Some college ❑ College graduate ❑ Advanced degree

**Marital status: ❑** Never married ❑Married ❑Divorced ❑Separated ❑Widowed ❑Partnered/Significant other

**Spiritual/Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your current or past occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever served in the military? Y/N Which branch?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Role:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently working? Y / N Hours/Week\_\_\_\_\_If not, are you? 🞎 Retired 🞎 Disabled 🞎 Sick leave**

**Do you receive disability or SSI? Y / N If yes, for what disability, how long?**

**SOCIAL HISTORY**

**Alcohol use: Y / N Drinks per day:\_\_\_\_\_\_\_\_\_\_\_Tobacco use: Y / N Amount per day:\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HISTORY**

**IF LIVING IF DECEASED**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Age** | **Health and Psychiatric** | **Age(s) at Death** | **Cause** |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Siblings |  |  |  |  |
| Siblings |  |  |  |  |

**EXTENDED FAMILY PROBLEMS PAST & PRESENT**

**Maternal Relatives:**

**Paternal Relatives:**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREVENTATIVES AND VACCINES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VACCINES** | **YES** | **NO** | **DATE** | **NOTES** |
| **Flu** |  |  |  |  |
| **Covid** |  |  |  |  |
| **Tdap** |  |  |  |  |
| **Shingles** |  |  |  |  |
| **Pneumonia** |  |  |  |  |
| **PREVENTATIVES** | **YES** | **NO** | **DATE** | **NOTES** |
| **Colonoscopy** |  |  |  |  |
| **Mammogram** |  |  |  |  |
| Pap |  |  |  |  |
|  |  |  |  |  |

NMIIS YES NO

(For office use only)

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FEMALES ONLY**

**REPRODUCTIVE HISTORY**

**Age of first period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**# Miscarriages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**# Abortions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**# Children (including step)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you reached menopause? Y / N At what age?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have regular periods? Y / N**