Patient Name: ______________________________ DOB: __________
Last First Middle
Today's Date: ________________________; MRN: _______________

Person Filling this Application Name: ___________________________

**Patient Information**

Name: ________________________________________________________ Date: _____________

Address: _________________________________________________________________________

Home / Cell Phone: ______________________ Email: ______________________________

Social Security #: _______-_______-_______ DOB: ___________________

Government ID Type: _______________ Number: ___________________ Exp.: ___________________

**Primary Care Physician**

Name: _________________________________ Telephone #: _______________________
Address: _________________________________________________________________________
Address City State Zip

**Insurance Information**

Insurance Name: __________________________ Subscriber I.D.: _________________________
Group Policy Number: __________________________

**Employer Information** [ ] Currently Employed [ ] Unemployed[ ] Retired [ ] Legally Disabled

Company Name: ______________________________ Telephone #: ________________________
Address: _________________________________________________________________________
Address City State Zip

**Emergency Contact**

Name: _______________________ Phone #: _______________ Relationship: _______________
Address: _________________________________________________________________________
Address City State Zip

**Preferred Pharmacy**

Name: ________________________________ Telephone #: ______________________________
Address: _________________________________________________________________________
Address City State Zip

Patient Name: _______________________________ DOB: __________
Last First Middle
Today's Date: _________________________; MRN: _______________

Person Filling this Application Name: ____________________________

***Please complete all fields:***

**Patient Medical History: (Medical Problem/ Date Diagnosed)**

_____________________________________________________________________ Resolved ☐ Yes ☐ No
_____________________________________________________________________ Resolved ☐ Yes ☐ No
_____________________________________________________________________ Resolved ☐ Yes ☐ No
_____________________________________________________________________ Resolved ☐ Yes ☐ No
_____________________________________________________________________ Resolved ☐ Yes ☐ No
_____________________________________________________________________ Resolved ☐ Yes ☐ No

**Patient Surgical History: (Surgery/ Date/ Reason)**

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

**List Allergies** (Medications, food and products):

_____________________________________________________________________________________________
_____________________________________________________________________________________________

**MEDICATION LIST** (name of & amount taken/day):

1.___________________________________________________________________________________________
2.___________________________________________________________________________________________
3.___________________________________________________________________________________________
4.___________________________________________________________________________________________
5.___________________________________________________________________________________________

***Family History:***

1.___________________________________________________________________________________________
2.___________________________________________________________________________________________
3. Personal or Family Hisotry of Blood Clots or use of blood thinners, Pleas elaborate _______________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

**Patient Social History:**

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation ___________________________________

Do you smoke? ☐ Yes ☐ No If yes, how many per day & years? __________

Do you use any street drugs? ☐ Yes ☐ No Specify: __________

Do you drink during pregnancy? ☐ Yes ☐ No If yes, how much? ________________________

Do you/others have concerns about your drinking? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? _________________

Domestic Violence/ Abuse? ☐ Yes ☐ No If yes, explain: __________________________________

***Patient Past Obstetrical History:***

*Are you Pregnant? ☐ Yes ☐ No If yes, what is the date of your last menstrual period: _____________*

*If note sure, do you want pregnancy test? ☐ Yes ☐ No Trouble Getting Pregnant: ☐ Yes ☐ No*

Number of Pregnancies: ____ Number of Abortions: ____ Number of Miscarriages: ____ Ectopic: ____

Have you had Cesarean section: ☐ Yes ☐ No If yes how many: ___________________

Have you had Vacuum or Forceps Deliveries: _____________ Have you had Epidural: __________________

Did you develpe Pre-Eclampsia or Diabeties in previous Pregnancy? : ☐ Yes ☐ No If yes, please specify:

_______________________________________________________________________________________________

Other Complication(s) during Last Pregnancy(S): ______________________________________________________

_______________________________________________________________________________________________

**Blood Transfusion:** ☐ Yes ☐ No if yes, how many units and dates: ________________________

Is Blood Transfusion acceptable to you: ☐ Yes ☐ No If No, why: ___________________________

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Long Beach, CA-90813

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**Patient Gynecological History:**

Age at first period ___________________ Is your period regular ☐ Yes ☐ No

Frequency of periods (in days) __________________ Duration (in days) ___________________

Amount: ☐ Light ☐ Moderate ☐ Heavy: Number of pads per day: ________________

Are you currently sexually active? ☐ Yes ☐ No How long with current partner? ___________

Unusual Vaginal Discharge ☐ Yes ☐ No Unusual itching/odor ☐ Yes ☐ No

Method of Birth Control used: ______________________________________________________________

Trouble Getting Pregnant: ☐ Yes ☐ No

Date of Last Pap-smear: ____________________ Abnormal Pap-smear ☐ Yes ☐ No

Abnormal Colonoscopy ☐ Yes ☐ No Date of Last Colonoscopy: __________________

Abnormal Mammogram ☐ Yes ☐ No Date of Last Mammogram: _________________

## Infections History:

Positive T.B. Test in past: ☐ Yes ☐ No

Live with someone with T.B.: ☐ Yes ☐ No

Rash or Viral Illness: ☐ Yes ☐ No

Genital Herpes: ☐ Yes ☐ No

History of Hepatitis: ☐ Yes ☐ No

Other Infections: ☐ Yes ☐ No; ___________________________________________________

History of Syphilis : ☐ Yes ☐ No

History of HIV: ☐ Yes ☐ No

Intercourse with person with HIV: ☐ Yes ☐ No

Other STD: ☐ Yes ☐ No

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**Questions or concerns to the doctor/ Reason for:**

______________________________________________________________________________

______________________________________________________________________________

**Are you currently having any problems related to the following systems? Circle Yes or No**

***Constitutional Symptoms***

| | | |
|---|---|---|
| Fever | ☐ Yes | ☐ No |
| Chills | ☐ Yes | ☐ No |
| Weight Loss/Gain | ☐ Yes | ☐ No |

***Allergic/Immunologic***

| | | |
|---|---|---|
| Food Allergies | ☐ Yes | ☐ No |
| Drug Allergies | ☐ Yes | ☐ No |

***Endocrine***

| | | |
|---|---|---|
| Excessive Thirst | ☐ Yes | ☐ No |
| Too hot/cold | ☐ Yes | ☐ No |
| Tired/Sluggish | ☐ Yes | ☐ No |

***Cardiovascular***

| | | |
|---|---|---|
| Chest Pain | ☐ Yes | ☐ No |
| Blood Clotting Problem | ☐ Yes | ☐ No |
| Swelling Legs | ☐ Yes | ☐ No |
| High/Low Blood Pressure | ☐ Yes | ☐ No |

***Respiratory***

| | | |
|---|---|---|
| Wheezing | ☐ Yes | ☐ No |
| Frequent Cough | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |

***Breast***

| | | |
|---|---|---|
| Breast Pain | ☐ Yes | ☐ No |
| Nipple Discharge | ☐ Yes | ☐ No |
| Breast Lumps | ☐ Yes | ☐ No |

***Neurological***

| | | |
|---|---|---|
| Headaches | ☐ Yes | ☐ No |
| Dizzy Spells | ☐ Yes | ☐ No |
| Numbness/Tingling | ☐ Yes | ☐ No |

***Eyes***

| | | |
|---|---|---|
| Blurred Vision | ☐ Yes | ☐ No |
| Double Vision | ☐ Yes | ☐ No |

***Gastrointestinal***

| | | |
|---|---|---|
| Abdominal Pain | ☐ Yes | ☐ No |
| Nausea/Vomiting | ☐ Yes | ☐ No |
| Indigestion/heartburn | ☐ Yes | ☐ No |

***Integumentary (skin)***

| | | |
|---|---|---|
| Skin Rash | ☐ Yes | ☐ No |
| Boils | ☐ Yes | ☐ No |
| Persistent Itch | ☐ Yes | ☐ No |

***Psychologic***

| | | |
|---|---|---|
| General Satisfaction with your life | ☐ Yes | ☐ No |
| Severe Depression | ☐ Yes | ☐ No |
| Considering Suicide | ☐ Yes | ☐ No |

***Genitourinary***

| | | |
|---|---|---|
| Urine Retention | ☐ Yes | ☐ No |
| Painful Urination | ☐ Yes | ☐ No |
| Urinary Frequency | ☐ Yes | ☐ No |

***Patient Signature:*** ______________________________________ ***Date:***____________________

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