Holmes Family Care

2564 NW Edenbower BLVD Ste126
Roseburg OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

Please note: we must maintain the most up to date and accurate information on our patients. In addition to the face sheet present to you at every visit, we will request that you review and update this form at least once a year.

Date: _____

Patient Information

First Name: _____ M.I: _____ Last Name: _____
SS#: _____ DOB: _____ Sex: _____ Pronouns: _____
Street Address: _____ Apt#: _____ City_____ ST: _____ ZIP: _____
Mailing Address (if different): _____ City: _____ ST: _____ ZIP: _____
Home Phone: _____ Cell: _____ Work: _____
Email: _____
Would you like to be signed up for the portal? O Yes O No

Please Check the boxes below:

Best Contact Method: O Home O Cell O Work O Email O Mail O Portal
By checking one of the boxes of best contact method, I agree to receive correspondence from HFC.
Material Status: O Single O Married O Divorced O Widowed O Separated O Life Partner

Employment Status: O Full-Time O Part-Time O Unemployed O Student O Disabled O Retired

Race: O White O African American O Asian O American Indian/Alaskan Native O Native Hawaiian/Pacific Islander O Declined O Other: _____
Ethnicity: O Non-Hispanic/Latino O Hispanic/Latino O Declined Preferred Language: O English O Spanish O Other_____
Do you have any communication difficulties/special needs? O No O Hearing Impaired O Interpreter required O Reading difficulty O visually impaired O Other: _____

How did you hear about our office: _____

Financially Responsible Party
O Same as patient information (if different, please fill out section below):

First Name: _____ M.I: _____ Last Name: _____
DOB: _____ Relationship: O Spouse O Parent O Guardian O Other:_____
Address: _____ APT#: _____ City: _____ ST: ____ ZIP: _____
Phone: Home: _____ Cell: _____ Work: _____
Email: _____ Employer: _____

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Emergency Contact Notification

Name: _____ Relationship: _____
Phone: Home: _____ Cell: _____

Name: _____ Relationship: _____
Phone: Home: _____ Cell: _____

Contact Detail Information
How would you like to be notified of Normal/Negative Lab/Imaging results? O Phone (ok to leave a voicemail) O Portal O Letter

How would you like to be reminded about appointments? O Text O Phone Call

Do we have permission to leave a detailed Voicemail O Yes O No
Insurance Information
Primary Insurance: _____
ID: _____ Group #: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship: O Self O Spouse O Parent O Other: _____
SSN: _____ Employer: _____

Secondary Insurance: _____
ID: _____ Group #: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Relationship: O Self O Spouse O Parent O Other: _____
SSN: _____ Employer: _____

Medication Refill Information
Please contact your pharmacy for refills. The Pharmacy will fax us medication request. Refill authorizations may take up to 72 hours to refill so please call before you run out of your medications.

Primary Pharmacy Name: _____ City: _____
Secondary Pharmacy Name: _____ City: _____

Primary Lab
O InterPath O LabCorp O Mercy O Quest

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OB Intake Form:

Date: _____

Full Name: _____ DOB: _____

Phone number: _____ Cell/Home/Work (circle one)

Mother's Occupation: _____

Father of baby's full name: _____ DOB: _____

Father's occupation: _____ Phone number: _____

Material Status: O Single O Married O Divorced O Widowed O Separated O Life Partner
Parents of Baby: O Married O live together O Divorced O Single Parent O Remarried

Number of adults/children in household: Adults: _____ Children: _____

Laboratory preference: O Mercy O Quest O Lab Corp O InterPath

Do you plan on Vaccinating your child? O Yes O No

OB History:

Heart Disease: O Yes O No

Autoimmune Disorder: O Yes O No

Neurologic/Epilepsy: O Yes O No

Hepatitis/Liver Disease: O Yes O No

Thyroid dysfunction: O Yes O No

History of Blood Transfusion: O Yes O No

D (RH) sensitized? O Yes O No

Seasonal Allergies: O Yes O No

Operations/Hospitalizations: O Yes O No

Uterine anomaly/DES: O Yes O No

Diabetes: O Yes O No

Hypertension: O Yes O No

Kidney Disease: O Yes O No

Depression/postpartum depression: O Yes O No

Varicosities/phlebitis: O Yes O No

Trauma/Violence: O Yes O No

Illicit/Recreational Drugs: O Yes O No

Pulmonary (TB, Asthma): O Yes O No

GYN Surgery: O Yes O No

Anesthetic Complications: O Yes O No

Infertility: O Yes O No

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Genetic Screening/Teratology Counseling: (For Mother and Father of the baby)

Patients age >35 years at estimated date of delivery: O Yes O No

Thalassemia (Italian, Greek, Mediterranean or Asian) MCV <80: O Mother O Father O Neither

Neural Tube Defect: O Mother O Father O Neither

Congenital Heart Defect: O Mother O Father O Neither

Down Syndrome: O Mother O Father O Neither

Tay-Sachs: O Mother O Father O Neither

Canavan Disease: O Mother O Father O Neither

Sickle Cell Disease or Trait: O Mother O Father O Neither

Muscular Dystrophy: O Mother O Father O Neither

Cystic Fibrosis: O Mother O Father O Neither

Hemophilia or other blood disorders: O Mother O Father O Neither

Mental retardation/Autism: O Mother O Father O Neither

If yes, was person tested for Fragile X? O Yes O No

Other Inherited genetic or chromosomal disorder: O Mother O Father O Neither

If yes, Name of disorder: _____

Maternal Metabolic Disorder: O Mother O Father O Neither

Birth Defects not listed: _____ O Mother O Father

Recurrent Pregnancy loss or still birth: O Yes O No

Medications/Illicit/Recreational drug/alcohol use since last menstrual period: O Yes O No

Infection History:
Live with someone with TB or exposed to TB: O Yes O No
Patient or partner with genital herpes: O Yes O No
Rash or Viral Illness since last menstrual period: O Yes O No
History of STD (Gonorrhea, Chlamydia ,HPV, Syphilis): O Yes O NO
If yes, which one? _____
History of MRSA: O Yes O No

Vaccinated or had Chickenpox (Mother and Father): _____

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Obstetric/Gynecological History:

Frequency of Cycles: ____ Days Age of first Menstrual Cycle: _____
When was the first day of your last menstrual cycle: _____
Were you on Birth Control at time of conception: O Yes O NO What form if yes: _____
Date that you took a pregnancy test: _____
Date of your last PAP: _____
Have you had any abnormal PAP results: O Yes O No If yes, Results: _____

Pregnancies: Total ___ Full term ___ Premature ___ Miscarriages ___ Abortions ___

Pregnancies in order, including miscarriages and abortions:

1. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____
2. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____
3. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____
4. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____

5. Date: _____ GA weeks: _____ Length of labor: _____
   Birth weight: ____ lbs. ____ oz Sex: O Male O Female
   Baby Name: _____ Type of delivery: O Vaginal O C-section
   Anesthesia: _____ Delivery Doctor: _____
   Place of Delivery: _____ Preterm Labor: O Yes O No
   Any complications during pregnancy/delivery: _____

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Medical History

Medications: O No change

Medications:	Dose:	Times Per Day

Allergies O No change

Allergy:	Reaction:

Surgeries O No change

Type (Specify Left/Right)	Date:	Location/Facility:

Hospitalizations: O No change

Reason:	Date:	Location/Facility:

Social History:

Tobacco Use:
Do you or have you ever smoke Cigarettes: O Yes O No (if yes please answer questions below)
Current: Pack/day: ___ Number of years: ___ Are you thinking about quitting: O Yes O No
Past: Quit Date: _____ Packs/day: _____ Number of years smoked: _____
Do you vape: O Yes O No

Do you use Marijuana or other recreational drugs: O Yes O No
Have you used drugs other than those for medical reasons in past 12 months: O Yes O No
Do you drink caffeine: O Yes O No How many cups per day: ____
Do you drink Alcohol: O Yes O No
Have you traveled outside the US in last 30 days: O Yes O No

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Family History:

Name: _____ DOB: _____

Family Members	Statues: (Alive or Deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	High Cholesterol	Cancer	Mental Illness
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Brother(s)								
Sister(s)								
Son(s)								
Daughter(s)								