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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Patient Medical History

Name: _____ DOB: _____

Medications

Medications:	Dose:	Times Per Day:

Past/Current Medical History

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma			
Cancer			Type:
Anxiety/Depression			
Diabetes			
COPD			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Thyroid Disease/issues			
Mental illness			
Kidney Disease			
Other:			
Other:			
Other:			

Allergies

Allergy	Reaction

Obstetric/Gynecological History

Age of first Menstrual cycle: _____ Date of Last Menstrual Cycle: _____

Menopause: O No O Yes When:_____

Manses monthly? O Yes O No Frequency of Cycles: ___ days O Regular O irregular

Currently on Birth Control? O Yes O No What Method or Type? _____

Pregnancies: Total____ Full Term___ Premature___ Miscarriages___ Abortions___

Surgeries

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

Hospitalizations:

Reason:	Date:	Location/Facility

Do you see any specialty doctors? O No O Yes

Office: _____ Specialty: _____ Reason: _____

Office: _____ Specialty: _____ Reason: _____

Office: _____ Specialty: _____ Reason: _____

Office: _____ Specialty: _____ Reason: _____

Social History

Occupation: _____ Employer: _____

O Retired O Unemployed O Disabled Years of Education or highest degree: _____

Marital Status: O Single O Partner O Married O Divorced O Widowed

Do you Drink Caffeine? O No O Yes How many cups per day: _____

Are you sexually Active? O No O Yes With O Males O Females O Both

Do you exercisė? O No O Yes How many times per week? _____

Nicotine/Alcohol/Recreational Drug Use:

Do you currently or have you ever smoked Cigarettes? O No O Yes(answer questions below)

Current: Pack/Day:_____ Number of years: ____ Are you thinking about quitting? O No O Yes

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 No O Yes What Kind? _____

Have you ever used needles to inject recreational drugs? O Yes O No

Preventive Screenings

Females:

- Last Cervical Cancer Screening (pap smear) Date: _____
- Have you had abnormal Pap results?
  - No
  - Yes Date: _____
- Last Mammogram: _____
- Last Colonoscopy or Colon cancer screening date: _____
- Last Osteoporosis (Dexa) Screening date: _____
- History of STD (Sexually transmitted disease): Please check all that apply.
  - None
  - Chlamydia. When: _____
  - Gonorrhea. When: _____
  - Syphilis. When: _____
  - Genital Herpes. When: _____
  - HIV/AIDS. When: _____
  - Other: _____ When: _____

Males:

- Last Colonoscopy of colon cancer screening date? _____
- Last Prostate Screening lab: _____
- Last Aortic Aneurism Screening? _____
- History of STD (Sexually transmitted disease):
  - None
  - Chlamydia. When: _____
  - Gonorrhea. When: _____
  - Syphilis. When: _____
  - Genital Herpes. When: _____
  - HIV/AIDS. When: _____
  - Other: _____ When: _____

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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)								