Darlena Pike, FNP-C
1201 NE 7th Street, Suite E
Grants Pass, Or 97526
Phone (541) 314-4894
Fax (541) 314-4895
QualityLifeFamilyPractice.com

New patient Information

Patient Information	
Name (last, first, middle initial)	Date of birth Gender M F
Mailing Address	Phone number (home/cell) Preferred contact method OK to leave message? Y N
Email address:	
Social Security No:	Marital Status (circle) Single Married Divorce Widow Partnered Separated
Preferred pharmacy:	

Insurance Information	
Primary Insurance Policy number Group number	Secondary Insurance (if applicable) Policy number Group number

In case of Emergency
Name of contact Relationship Phone number

Referral Source
We would appreciate learning who you were referred by

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The following questions are strictly voluntary and used for Meaningful Use purpose			
Race:	☐ Declined	☐ American Indian/Alaska Native ☐ Black/African American ☐ Nat Hawaiian/Pacific Islander	☐ Asian ☐ White ☐ Other
Ethnicity:	☐ Declined	☐ Hispanic/Latino	☐ Not Hispanic/Latino

Past Medical History

If you have had any of these medical problems, please circle.

Anemia	Edema	Vision loss
Anxiety	Hearing Loss	
Angina (chest pains)	Heart Attack	Cancer: Please list
Asthma	Hepatitis	_____
Arthritis/Osteoarthritis	High Cholesterol	_____
Back pain	High blood Pressure	_____
Bipolar disorder	Insomnia	_____
COPD/emphysema	Kidney Disease	
Cough (chronic)	Liver Disease	Males:
Chronic Pain	Osteoporosis	Prostate issues
Deep Vein Thrombosis	Seizure Disorder	
Dementia	Stroke or TIA's	Females:
Depression	Urinary concerns	Menstrual problems
Diabetes Type I or II	Vertigo/dizziness	Uterine fibroids

Other medical problems not listed above _____
_____

Females:
LMP _____ Contraception _____
Pregnancies _____ Live births _____ Abortions _____ Miscarriages _____
Last Mammogram _____

Are you followed by any specialists? _____

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Medications

Medication	Dosage	Frequency

Supplements: _____

_____

_____

Allergies: _____

_____

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Past Surgical History

If you have had any of these surgical procedures, please circle and write in date.

Appendix	Hernia Repair
Amputation	Hysterectomy
Back Surgery	Laparoscopic (diagnostic)
C- Section	Mastectomy
Cardiac surgery	Melanoma Removal
Carpal Tunnel Release	Skin cancer biopsy
Endoscopy	Tonsillectomy
Gall Bladder	Prostate surgery

Other operations, please list with date: _____
_____
_____

Family Medical History

Has any blood relative had any of the following problems? List relationship.
Only include parents, grandparents, and siblings.

Alzheimer/Dementia _____
Anemia _____
Cancer (type) _____
Diabetes, Type I or II _____
Heart Disease _____
High blood pressure _____
Kidney disease _____
Liver disease _____
Mental Health Issues (type) _____
Osteoporosis _____
Stroke _____

Other family medical problems not listed. _____
_____
_____

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Social History

Smoking history: yes no

Current use (packs per day) _____ Past use: (When quit) _____

Alcohol – current use _____ Average use in past _____
Do you consider yourself an alcoholic _____

Recreational drugs (past or present) _____

Employment:
☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Retired
Employer _____

Do you have any hobbies? What do you like to do for fun? _____
_____
_____
_____
_____

Is there anything else you would like to add so that we may get to know you better?

_____ _____
Signature Date Completed