PATIENT DEMOGRAPHIC INFORMATION

Legal First Name:

Middle Name:

Legal Last Name:

Date of Birth (mm/dd/yyyy):

Sex: ☐ Male ☐ Female ☐ Undifferentiated

Race: ☐ White ☐ Hispanic ☐ African American
☐ American Indian ☐ Asian ☐ Other: _____

SSN:

Address 1:

Address 2:

City:

State: **Zip:**

Language:

Marital Status: ☐ Never Married ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partner
☐ Other: _____

Pregnant: ☐ **YES** ☐ **NO**

EMPLOYMENT INFORMATION

Employment Status: ☐ Employed ☐ Unemployed
☐ Full-time Student ☐ Part-time Student
☐ Other: _____

Employer Name:

Employer Phone:

Address 1:

Address 2:

City:

State: **Zip:**

PATIENT CONTACT INFORMATION

Home Phone:

Work Phone: **Ext.**

Cell Phone:

Email:

Written Contact Preference: : ☐ Email ☐ Postal Mail

EMERGENCY CONTACT INFORMATION

First Name:

Last Name:

Emergency Phone:

Relation to Patient:

Address 1:

Address 2:

City:

State: **Zip:**

PRIMARY CAREGIVER

First Name:

Last Name:

Relationship:

LEGAL GUARDIAN

First Name:

Last Name:

Relationship:

HEALTHCARE PROXY

First Name:

Last Name:

Relationship:

PLEASE FILL OUT & RETURN TO FRONT DESK. Today's Date: _____

Name: _____ DOB:_____

Medical History: *Please check those conditions that NOW or HAVE EVER applied to you:*

□ Asthma	□ Dementia	□ Breast Cancer	□ Enlarged Prostate	□ Migraine	□ High Cholesterol
□ Anemia	□ Dermatitis	□ Depression	□ Heart Attack	□ Gout	□ High Blood Pressure
□ Arthritis	□ Diabetes	□ Pneumonia	□ Hepatitis	□ Headache	□ Coronary Artery Disease
□ Anxiety	□ Epilepsy	□ HIV	□ Back Problems	□ Thyroid Disease	□ Congestive Heart Failure
□ COPD	□ GERD	□ Renal Stone	□ Glaucoma	□ Ulcer □ Stroke	□ Tuberculosis (TB)

□ Other Cancer *What type?* _____

Other conditions not listed above? _____

Medication List: *Please list any medications you are currently taking:*

_____

_____

_____

Any recent immunizations or injections? *(ex. flu shot, covid shot, pneumonia, tetanus, hepatitis, shingles, etc.)* □ Yes □ No *Please list:*

_____

Allergies: □ Yes □ No *If yes, please list:* _____

_____

Surgical History: *Please fill out past surgical history:* _____

_____

_____

Obstetric History: Are you currently pregnant? □ Yes □ No *If yes, how many weeks?*_____

Total Preg	Full Term	Premature	Ab Induced	Ab Spontaneous	Ectopics	Multiple Births	Living

Social History:

Do you smoke? □ Yes □ No *If yes, how often, how much?*_____

Do you drink? □ Yes □ No *If yes, check all that apply:* □ beer □ wine □ hard alcohol

How often & how much? _____

Do you currently take or have you taken any illegal drugs or abused prescription drugs? *(ex. cocaine, heroin, oxycodone, amphetamines, etc.)*

□ Yes □ No *If yes, how often & how much?* _____

Family History: *Check any **RELEVANT** conditions associated with family members and fill in the relationship.)Check **"M"** for **Maternal** and **"P"** for **Paternal** when specifying Mother or Father's side of the family).*

	✔Yes	✔No	Relationship		✔Yes	✔No	Relationship
□ Asthma			□ **M** □ **P**	□ Enlarged Prostate			□ **M** □ **P**
□ Anemia			□ **M** □ **P**	□ Heart Attack			□ **M** □ **P**
□ Arthritis			□ **M** □ **P**	□ Hepatitis			□ **M** □ **P**
□ Anxiety			□ **M** □ **P**	□ Back Problems			□ **M** □ **P**
□ COPD			□ **M** □ **P**	□ Glaucoma			□ **M** □ **P**
□ Dementia			□ **M** □ **P**	□ Migraine			□ **M** □ **P**
□ Dermatitis			□ **M** □ **P**	□ Gout			□ **M** □ **P**
□ Diabetes			□ **M** □ **P**	□ Headache			□ **M** □ **P**

							See other side….
	✔Yes	✔No	Relationship		✔Yes	✔No	Relationship
□ Epilepsy			□ **M** □ **P**	□ Thyroid Disease			□ **M** □ **P**
□ GERD			□ **M** □ **P**	□ Ulcer			□ **M** □ **P**
□ Stroke			□ **M** □ **P**	□ High Cholesterol			□ **M** □ **P**
□ Breast Cancer			□ **M** □ **P**	□ High Blood Pressure			□ **M** □ **P**
□ Depression			□ **M** □ **P**	□ Coronary Artery Disease			□ **M** □ **P**
□ Pneumonia			□ **M** □ **P**	□ Congestive Heart Failure			□ **M** □ **P**
□ HIV			□ **M** □ **P**	□ Tuberculosis (TB)			□ **M** □ **P**
□ Renal Stone			□ **M** □ **P**				□ **M** □ **P**
			□ **M** □ **P**				□ **M** □ **P**
			□ **M** □ **P**				□ **M** □ **P**

*Fill out those who are **DECEASED**. If known, fill in the **age at death** and the **cause of death**.*

Family Member	**Death Age**	**Cause of Death**	**Family Member** *(Brothers & Sisters)*	**Death Age**	**Cause of Death**
Father			□ M □ F		
Mother			□ M □ F		
Maternal Grandmother			□ M □ F		
Maternal Grandfather			□ M □ F		
Paternal Grandmother			□ M □ F		
Paternal Grandfather			□ M □ F		

□ **Adopted** □ **History Unknown**

Other comments: _____

_____

PREVENTATIVE CARE: *(Please fill out all that apply)* **Have you had any of the following, if so, date, Doctor/Facility name?**

Colonoscopy: □ Yes □ No Date:	Doctor/Facility:
WOMEN ONLY:	
Mammogram: □ Yes □ No Date:	Doctor/Facility:
Pap Smear: □ Yes □ No Date:	Doctor/Facility:
DIABETICS ONLY:	
Retinal Eye Exam: □ Yes □ No Date:	Doctor/Facility:
Last A1c / Labs: □ Yes □ No Date:	Doctor/Facility: