

NAME _____ AGE _____ DATE _____

OCCUPATION _____ BIRTHPLACE _____ DOB _____

PERSONAL HISTORY: Referring Dr (if any) _____

CURRENT SYMPTOMS:

- | | | | |
|----|---|----------|----------|
| 1. | HAVE YOU HAD: A TONSILLECTOMY | Y | N |
| 2. | HAVE YOU HAD: AN APPENDECTOMY | Y | N |
| 3. | Have you ever been advised to have a
surgical procedure which has NOT been done? | Y | N |
| 4. | | | |

DOCTORS LAST SEEN/DATES/ISSUES:

ARE YOU ALLERGIC TO:

- | | | | |
|----|------------|----------|----------|
| 1. | PENICILLIN | Y | N |
| 2. | SULFA | Y | N |
| 3. | ASPIRIN | Y | N |

LIST ALL MEDICATIONS AND DOSAGES:

LIST ALL OTHER MEDICATION ALLERGIES

- | | |
|----|-----------------------|
| 1. | AND REACTIONS: |
| 2. | 1. |
| 3. | 2. |
| 4. | 3. |

HOSPITALIZATIONS/SURGERIES/DATES/DRS

FEMALES ONLY:

- | | | | |
|----|--------------------------------------|----------|----------|
| 1. | Are you pregnant or breastfeeding? | Y | N |
| 2. | Date of last menstrual period? _____ | | |
| 3. | | | |

ILLNESSES: Please circle any below illnesses that you have had in the past:

- | | | |
|-------------------------|----------------------|-------------------------|
| HEART ATTACK | MIGRAINE HEADACHES | HERPES |
| DIABETES | EPILEPSY OR SEIZURES | OTHER VENERAL DISEASE |
| CANCER | STROKE | BLADDER DISEASE |
| HIGH BLOOD PRESSURE | TUBERCULOSIS | KIDNEY PROBLEMS |
| RHEUMATIC FEVER | HAY FEVER | COLITIS OR BOWEL ISSUES |
| PNEUMONIA OR ASTHMA | GONORRHEA | HEMMORHOIDS |
| POLIO OR MENINGITIS | SYPHILIS | STOMACH ISSUES/ULCERS |
| LIVER PROBLEMS/JAUNDICE | GALLBLADDER DISEASE | HIVES OR EDEMA |

FAMILY HISTORY:

ANY OF THE FOLLOWING IN THE LAST 6 MONTHS

IF LIVING, LIST AGE AND HEALTH OF

FAMILY MEMBER-IF DECEASED, LIST CAUSE OF DEATH:

FATHER:

MOTHER:

BROTHER OR SISTER 1.

2.

3.

4.

HUSBAND OR WIFE: _____

SON OR DAUGHTER: 1.

2.

3.

4.

CHEST PAIN **Y N**

HEADCHES **Y N**

HEART PALPITATIONS **Y N**

SHORTNESS OF BREATH **Y N**

DIFFICULTY WALKING **Y N**

ARTHRITIS / RHEUMATISM **Y N**

BONE AND JOINT DISEASE **Y N**

URINATING PROBLEMS **Y N**

SEXUAL DYSFUNCTION **Y N**

BLOOD IN STOOL **Y N**

ANEMIA **Y N**

DEPRESSION

HAVE YOU HAD ANY MAJOR INJURIES: **Y N**

BACK OR NECK INJURIES **Y N**

EVER BEEN KNOCKED UNCONCIOUS **Y N**

HAS ANY BLOOD RELATIVE HAD: (Please circle)

BREAST CANCER **Y N**

COLON CANCER **Y N**

OTHER CANCER **Y N**

TUBERCULOSIS **Y N**

DIABETES **Y N**

HEART TROUBLE **Y N**

HIGH BLOOD PRESSURE / STROKE **Y / N**

THYROID ISSUES **Y / N**

GLAUCOMA **Y / N**

IMMUNIZATIONS:

TETANUS SHOT **Y N** DATE _____

FLU SHOT **Y N** DATE _____

PNUEMOVAX **Y N** DATE _____

DID YOU HAVE ANY REACTION TO A SHOT **Y N**

WHEN WAS YOUR LAST :

PHYSICAL EXAM _____

GLUCOSE OR CHOLESTROL TEST _____

FLEXIBLE SIGMOIDOSCOPY (OVER 50)

BREAST EXAM & MAMMOGRAM _____

SOCIAL HISTORY: DO YOU SMOKE **Y N** HOW MANY PACKS PER DAY ____ HOW MANY YEARS _____

CHEW TOBACCO **Y N** HOW LONG _____ IV DRUGS/COCAINE **Y N**

DRINK ALCOHOL **Y N** HOW OFTEN _____ HOW MANY YEARS _____

SEXUAL PREFERENCE: HETEROSEXUAL _____ HOMOSEXUAL _____ BISEXUAL _____

Basic Information

Full Name _____
First Middle Last Suffix

Sex Male Female Unknown

Date of Birth _____

Primary Phone Home Mobile Work

Phone Number _____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____

State Washington Zip _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License # _____

Demographics

Sexual Orientation _____

Gender Identity _____

Hispanic or Latino? Yes No Decline to Specify

Ethnicity _____

Race _____

Language _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone Home Mobile Work

Phone Number _____

Email _____

Address Line 1 _____

Address Line 2 _____

City _____

State Zip _____

Financial Information

Responsible Party

Who will be financially responsible for you? Myself Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact

Full Name

First

Middle

Last

Primary Phone Home Mobile Work

Phone Number

Method of Payment

What will be your method of payment? Insurance Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company Regence

Policy Number

Insurance Plan

Insurance Phone Number

Group Number

Insurance Company Address

Address Line 2

City

State

Zip

Relationship to Primary Policy Holder self

If you are not the primary policy holder, please fill out the following:

Full Name

First

Middle

Last

Sex Male Female Unknown

Date of Birth

Policy ID Number

Social Security Number

Policy Holder Address

Address Line 2

City

State

Zip

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____ Policy Number _____

Insurance Plan _____ Insurance Phone Number _____

Group Number _____

Insurance Company Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Relationship to Secondary Policy Holder _____

If you are not the secondary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex Male Female Unknown Date of Birth _____

Insurance ID Number _____ Social Security Number _____

Policy Holder Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? Previous Patient