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PATIENT INFORMATION

Today's Date: Gender: Date of Birth: Age:
Last Name: First Name: MI:
SSN# E-mail Address:
Street Address:
City: State: Zip:
Home #: Work #: Cell #:
Employer:
Race/Ethnicity Preferred Language:
Marital Status: Single Married Divorce Separated Partnered Widowed
Emergency Contact: Relationship to Patient:
Emergency Contact Phone #:

INSURANCE INFORMATION

Primary Insurance: Secondary Insurance:
Subscriber's Name:
Subscriber's Date of Birth:
Subscriber's SSN:
ID #:
Group #:
Secondary Insurance:
Subscriber's Name:
Subscriber's Date of Birth:
Subscriber's SSN:
ID #:
Group #:

Reason for today's visit:
If Injured: Where you injured on the job? (Circle) Yes No Injury Date:

I authorize treatment and the release of medical information acquitted in my treatment to process claims to my insurance company. I authorize direct payment from my insurance company to Primary Care Savannah. I recognize and accept responsibility for services rendered regardless of Insurance coverage. This Includes but is not limited to co-insurance, co-payment, deductible and non-covered services. I understand that payment in full will be required at the time of service if I decided I want to file my own claim. I have received a Notice of Privacy Practices from Primary Care Savannah.

Signature of Responsible Party: Date:

SURGERY/HOSPITALIZATIONS

1. Have you every had surgery? Yes No
2. Please list approximate dates and reasons for any surgery or other conditions (including childbirth) that required hospitalizations: *(a separate list may be provided)*

Date	Reason for hospital stay
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FOR OFFICE USE

SOCIAL HISTORY

Work Status

1. Employment/Work (Job/School/Play)
 Working Full-Time Working Part-Time
 Regular Duty Light Duty
2. Occupation: _____
 Student Retired Unemployed Disabled

Cultural/Religious

1. Are there any customs or religious beliefs or wishes that might affect your care? Yes No
a. Please Explain: _____

Social/Health Habits

1. Smoking
a. Do you currently use tobacco products? Yes No
If yes: Cigarettes Cigars/Pipes Smokeless
How many packs/day: _____
If no: Have you used tobacco in the past? Yes No
Year Quit: _____

2. Alcohol
a. How many days per week do you drink beer, wine other alcoholic beverages? _____
b. If 1 beer, 1 glass of wine or 1 cocktail equals 1 drink, how many drinks do you have in an average week? _____
3. Caffeine
a. How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
4. Exercise
a. Do you exercise regularly
 Yes No Type: _____
b. On average, how many days per week do you exercise?

c. For how many minutes, on an average day?

5. General Health Status. Please rate your health:
 Excellent Good Fair Poor

Living Environment

1. With whom do you live?
 Alone Spouse only
 Spouse and others Child (not spouse)
 Other relative(s) Group Setting
 Personal Care Attendant
 Other: _____

Other

1. Primary Language:
 English Other: _____
Do you need an interpreter? Yes No
2. Learning Barriers
 None Vision
 Hearing Unable to read
 Unable to understand what is read
 Other: _____

FOR OFFICE USE

Patient/Guardian Signature: _____ Date: _____/_____/_____

Reviewed By: _____ License #: _____ Date: _____/_____/_____

CHECKLIST: REVIEW OF SYSTEMS

GENERAL

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble sleeping

SKIN

- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Hair and nail changes

HEAD

- Headache
- Head injury
- Neck Pain

EARS

- Decreased hearing
- Ringing in ears
- Earache
- Drainage

EYES

- Vision Loss/Changes
- Glasses or contacts
- Pain
- Redness
- Blurry or double vision
- Flashing lights
- Specks
- Glaucoma
- Cataracts
- Last eye exam

NOSE

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

THROAT

- Bleeding
- Dentures
- Sore tongue
- Dry mouth
- Sore throat
- Hoarseness
- Thrush
- Non-healing sores

NECK

- Lumps
- Swollen glands
- Pain
- Stiffness

BREASTS

- Lumps
- Pain
- Discharge
- Self-exams
- Breast-feeding

RESPIRATORY

- Cough
- Sputum
- Coughing up blood
- Shortness of breath
- Wheezing
- Painful breathing

CARDIOVASCULAR

- Chest pain or discomfort
- Tightness
- Palpitations
- Shortness of breath with activity
- Difficulty breathing lying down
- Swelling
- Sudden awakening from sleep with shortness of breath

GASTROINTESTINAL

- Swallowing difficulties
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Rectal bleeding
- Constipation
- Diarrhea

- Yellow eyes or skin

URINARY

- Frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinence
- Change in urinary strength

VASCULAR

- Calf pain with walking
- Leg cramping

MUSCULOSKELETAL

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

NEUROLOGIC

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor

HEMATOLOGIC

- Ease of bruising
- Ease of bleeding

ENDOCRINE

- Head or cold intolerance
- Sweating
- Frequent urination
- Thirst
- Change in appetite

PSYCHIATRIC

- Nervousness
- Stress
- Depression
- Memory loss