



Please complete form in its entirety

Patient Information	Patient Information:					
	Last Name:		First Name:		M.I.:	Date of Birth:
	Mailing Address:			Apt #		
	City/State/Zip:					
	Home Phone:		Cell Phone:		Work Phone:	
	Email Address:				Preferred Method of Contact: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email	
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender			Social Security #:		
	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other _____			Employer Name:		
	Emergency Contact Name and Phone:			Relationship to Patient:		
Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:					
	Last Name:			First Name:		
	Date of Birth:		Social Security #:		Phone:	
	Address of Person Responsible:					
	City/State/Zip:			Relationship to Patient:		
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):					
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline			Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline		
Preferred Language (please select one):		<input type="checkbox"/> English	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Indian (including Hindi & Tamil)		
		<input type="checkbox"/> Sign Language	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian		
Preferred Pharmacy Name & Location:						
Insurance Information	Primary Medical Insurance		Secondary Medical Insurance			
	Ins. Co. Name:		Ins. Co. Name:			
	Member ID & Group #:		Member ID & Group #:			
	Policy Holder Name:		Policy Holder Name:			
	Policy Holder Date of Birth:		Policy Holder Date of Birth:			
	Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:			



Name: _____ Allergies _____

Please list ALL medications you are currently taking, prescribed and or over the counter. Please try and be as specific as possible.

Medication	Dosage	Route	Frequency

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

- | | | | |
|-----------------------------------|---------------------|-----------------------------|----------------------|
| ADHD | COPD/ Emphysema | High Cholesterol | Rheumatoid Arthritis |
| Alcoholism | Dementia | HIV | Seizure Disorder |
| Allergies, Seasonal | Depression | Hepatitis | Sleep Apnea |
| Anemia | Diabetes: 1 or 2 | Irritable Bowel Syndrome | Stroke |
| Anxiety | Diverticulitis | Lupus | Thyroid Disorder |
| Arrhythmia (irregular heart beat) | DVT (Blood Clot) | Liver Disease | Ulcerative Colitis |
| Arthritis | GERD (Acid Reflux) | Macular Degeneration | |
| Asthma | Glaucoma | Neuropathy | |
| Bipolar | Heart Disease | Osteopenia/Osteoporosis | |
| Bladder Problems / Incontinence | Heart Attack (MI) | Parkinson's Disease | |
| Bleeding Problems | Hiatal Hernia | Peripheral Vascular Disease | |
| Cancer: _____ | High Blood Pressure | Peptic Ulcer | |
| Headaches | Kidney Stones | Psoriasis | |
| Crohn's Disease | Kidney Disease | Pulmonary Embolism (PE) | |

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date: _____	Normal Abnormal
Mammogram	Yes/No Date: _____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date: _____	Normal Abnormal
Pap	Yes/No Date: _____	Normal Abnormal

Other medical problems not listed above:

Surgical History: Please list all prior surgeries and approximate dates performed.

SOCIAL / CULTURAL HISTORY:

- Are there any vision problems that affect your communication? Yes No
- Are there any hearing problems that affect your communication? Yes No
- Are there any limitations to understanding or following instructions (either written or verbal)? Yes No

Current Living Situation (Check all that apply):

- Single Family Household Multi-generational Household Homeless Shelter Skilled Nursing Facility Other: _____

Smoking/ Tobacco Use: Current Past Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: Current Past Never Drinks/week: _____

Recreational Drug Use: Current Past Never Type: _____

Are you sexually active? Yes No

Are there any personal problems or concerns at home, work, or school you would like to discuss? Yes No

Are there any cultural or religious concerns you have related to our delivery of care? Yes No

Are there any financial issues that directly impact your ability to manage your health? Yes No

How often do you get the social and emotional support you need?

Always Usually Sometimes Rarely Never

Comments (Please feel free to comment on any answers marked "yes" above):

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

Patient Signature _____