Welcome To Our Office!

Name: _____ Date: _____
Home Address: _____
City: _____State:_____ Zip:_____
Home Phone: _____ Cell Phone: _____
Email address: _____
(You will receive a confirmation e-mail with your username and temporary password to access our patient portal)
DOB: _____ Age: _____SSN:_____
Employer: _____
Employer's Address: _____
City: _____State:_____ Zip:_____
Work Phone: _____ May we contact you at work? YES NO

Name of Spouse: _____
Employer: _____
Employer's Address: _____
_____State:_____ Zip: _____
Work Phone: _____

In case of an emergency, contact: _____ Relationship:_____
Home Phone: _____ Cell Phone: _____

Complete this section only if someone other than the patient is financially responsible:
Responsible Party: _____ Relationship to patient: _____
Home Address: _____
City: _____State:_____ Zip:_____
Home Phone: _____ Cell Phone: _____
DOB: _____ Age: _____SSN:_____
Employer: _____
Employer's Address: _____
City: _____State:_____ Zip:_____
Work Phone: _____

We are now required to collect race, ethnicity and language. If you prefer not to answer this question, you may mark the box "Decline."

Race:

- ☐ White
- ☐ Black or African American
- ☐ Hispanic
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Other
- ☐ Decline

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Indian
- ☐ Vietnamese
- ☐ Other
- ☐ Decline

Past Medical History:

Please review the list below and check any problems you have had, now or in the past.

- ☐ Abnormal Pap Smear
- ☐ Acne
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer (Specify)_____
- ☐ Chronic Bronchitis
- ☐ Crohn's Disease or IBS
- ☐ Colon Polyps
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Emphysema
- ☐ Frequent UTI's
- ☐ Frequent Sinus Infections
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Condition (Specify)_____
- ☐ Hepatitis (A,B,C)_____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Melanoma or Skin Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Positive TB Skin Test
- ☐ Prostate Problems
- ☐ Psoriasis
- ☐ Reflux (heartburn)
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ STD's (Specify)_____
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Warts

Other medical problems not listed: _____

Please check or list all the surgeries you have had and the year they were performed:

Type of surgery	Year	Type of Surgery	Year
☐ Appendectomy……		☐ Hysterectomy……..	
☐ Arthroscopy ……		☐ Knee or Hip Replacement……..	
☐ Back or Neck surgery……		☐ Mastectomy or Lumpectomy….	
☐ Cataract Surgery……..		☐ Polyp Removal (colon)…….	
☐ Cesarean Surgery……		☐ Tonsillectomy/Adenoidectomy..	
☐ Gallbladder Removal……		☐ Tubal Ligation or Vasectomy……	
☐ Heart Surgery (specify)…		☐ Plastic Surgery (specify)……	
☐ Hemorrhoids……		☐ Other (specify)……	
☐ Hernia……..			

Other Surgeries: _____

Other Hospitalizations: _____

Allergies: **NONE**

List anything you are allergic to, (medications, food, bee stings, etc.) and how each affects you.

Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____

Family History:

Have any of your family members had any of the following problems? If so, please list family member.

Condition	Family Member	Condition	Family Member
☐ Heart Disease/Attack	_____	☐ Osteoporosis	_____
☐ Stroke	_____	☐ Migraines	_____
☐ Diabetes	_____	☐ Breast Cancer	_____
☐ High Blood Pressure	_____	☐ Colon Cancer	_____
☐ High Cholesterol	_____	☐ Prostate Cancer	_____
☐ Thyroid Disease	_____	☐ Lung Cancer	_____
☐ Depression	_____	☐ Ovarian Cancer	_____
☐ Other Mental Illness	_____	☐ Uterine Cancer	_____
☐ Alcoholism	_____	☐ Skin Cancer	_____
☐ Asthma	_____	☐ Other Cancer	_____

Any other illness in the family not listed? _____

Current Medications: **NONE**

List the dose and frequency.

Medication	Dose	Frequency	Medication	Dose	Frequency
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

For Women:

Last menstrual period:___/____/____	Age of first period:____	# of pregnancies:___
Last pap smear: ___/____/____	# of days in cycle: ____	# of live births: ___
Last mammogram: ___/____/____	# of days in flow: ____	# of miscarriages: ___
Last bone density: ___/____/____	Are you Menopausal? Y N	# of abortions: ___
	-Age of onset____	

Social History:

Tobacco Smoking: [ ] Never [ ] Former: Year quit:_____[ ] Current smoker: ____pack(s)/day x____years

Other Tobacco Use: [ ] No [ ] Yes; please specify:_____

Recreational Drug Use: [ ] No [ ] Yes; please specify: _____

Have you ever abused any drugs? [ ] No [ ] Yes; please specify: _____

Alcohol Use: [ ] Never [ ] Socially [ ] Weekends [ ] Daily Specify Quantity:_____

Caffeine use: [ ] Never [ ] Rarely [ ] Often [ ] Daily Specify Source: _____

Exercise: [ ] Never [ ] 2-3 days/week [ ] 4-7 days/week

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Committed Relationship

Please tell us if you have had any of the following screening tests, and the most recent date:

Colonoscopy: _____ (date)

DEXA (bone density): _____ (date)

Cardiac Stress Test: _____ (date)

Adult Immunizations:

Tetanus: [ ] Yes [ ] No Date: ___/___/____ -Was Pertussis included the (Tdap)? [ ] Yes [ ] No

Pneumonia: [ ] Yes [ ] No Date: ___/___/____

Hepatitis B: [ ] Yes [ ] No (1) Date: ___/___/____ (2) Date: ___/___/____ (3) Date: ___/___/____

HPV: [ ] Yes [ ] No (1) Date: ___/___/____ (2) Date: ___/___/____ (3) Date: ___/___/____

How did you hear about our office? _____

Please add any other information about your health that you would like your provider to know.

_____

_____

_____

_____

_____ _____

Patient Signature Date