SoutheastHEALTH

PATIENT INFORMATION FORM

Patient Name: ____

Date of Birth: (M/D/Y) ____________________ **Birth Sex:** [ ] Male [ ] Female **SSN:** (patient) _______________

Previous and/or Maiden Name: ____

Parent/Legal Guardian Name: (if patient is a minor) __________________ **SSN :**(Parent/guardian) ____________

Address: ____ **City:** _____________ **State:** ______ **Zip:** ___________

Home Phone: ___________________ **Cell Phone:** ____________________ **Work Phone:** ____________________

Email: ____ **Marital Status:** [ ] Single [ ] Married

Language: [ ] English [ ] Spanish [ ] Other: ____________________

Race: [ ] Caucasian/White [ ] Black/African American [ ] American Indian [ ] Asian [ ] Hispanic/ Latino
[ ] Other: ____________________

EMPLOYMENT AND INSURANCE

Patient or Parent's Employer: ______________________________ **Occupation:** ____________________________

Primary Insurance Company: ____
Policy Holder's Name: ____**Date of Birth:** ______________________
Policy Holder's Employer: ____________________________________**Occupation:**______________________
Relationship to Patient: ______________________________________**SSN:**________________________________

Secondary Insurance Company: ____
Policy Holder's Name: ____**Date of Birth:** ______________________
Policy Holder's Employer: ____________________________________**Occupation:**______________________
Relationship to Patient: ______________________________________**SSN:**________________________________

EMERGENCY CONTACT

Name: ____**Relationship:** ______________________________
Phone Number: _______________________________________ **Date of Birth:** ______________________________

Name: ____**Relationship:** ______________________________
Phone Number: _______________________________________ **Date of Birth:** ______________________________

Power of Attorney: _______________________________

Do you have an Advanced Directive? (End of Life Care) [ ] Yes [ ] No

I consent for staff to leave a voice mail pertaining to your health information. [ ] Yes [ ] No

____ ________________________________

Signature of Patient or Guardian Date

Legal Name: __________________ **Preferred name** (*if different*)**:**__________________ **DOB:**________ **Date:** ________

Sex: Male Female **Identifies as:** Male Female Other**:** ______________

Preferred Pharmacy: Broadway Prescription Shop CVS CVS in Target Schnucks

WM Super Center Cape WM Neighborhood Market (Cape) Walgreens **Other:** _______________

Medications (Prescription and Over the counter):

☐ **None**

Name	Dose	Frequency

Allergies (including food and medication):

☐ **None**

Name	**Reaction**

Females only:

Age at first menstrual cycle	
First day of last menstrual cycle	
Date of last pap smear (if applicable)	
Have you ever been pregnant?	**Yes or No If so, how many?**
If circled yes to pregnancy, how many are living?	

Past medical history (Check all that applies, if not listed please write in next to other**)**

☐ **None**

	ADHD		Diabetes: 1 or 2		Seizure disorder
	Allergies, environmental		GERD		Stroke
	Allergies, seasonal		Headache, Migraine		Thyroid Disease
	Anemia, if so type:		Heart disease		Schizophrenia
	Anxiety		Heart valve disorder		Post-traumatic Stress Disorder
	Arthritis		Hepatitis		Other:
	Asthma		High Cholesterol		
	Bipolar Disorder: I or II		High Blood Pressure		
	Cancer, if so type:		Inflammatory Bowel Disease		
	Cardiac arrhythmia		Irritable Bowel Syndrome		
	Depression		Osteoporosis		

Past Surgical History (Check all that applies and when it was performed):

☐ **None**

	Surgery	**Date**		**Surgery**	**Date**
	Appendectomy			Knee replacement	
	Arthroscopy			Mastectomy	
	Back Surgery			Thyroidectomy	
	Bilateral Tubal Ligation			Tonsillectomy	
	Breast Augmentation			Other:	
	Cardiac Pacemaker				
	Carpal Tunnel Release				
	Cholecystectomy (gallbladder removal)				
	Colostomy				
	Dilation and curettage				
	Hip replacement				

Family History (Check all that applies, please specify family member affected)

(If extended family specify if maternal or paternal)

☐ **None**

		Person			**Person**
	ADHD			Hearing disorder	
	Alcoholism			High Blood Pressure	
	Allergies			Inflammatory Bowel Disease	
	Alzheimer's Disease			Irritable Bowel Syndrome	
	Arthritis			Mental Illness	
	Asthma			Migraine	
	Blood Disorder			Obesity	
	Cancer, if so type:			Osteoporosis	
	Cardiovascular disease			Peripheral Vascular Disease	
	Coronary Artery Disease			Renal Disease	
	Depression			Seizure Disorder	
	Diabetes: Type 1 or 2			Stroke	
	Eczema			Thyroid Disorder	
	High Cholesterol			Other:	
	Genetic Disease				

Social History:

Preferred Language: ________________ Native Language (if different from preferred): _________________

Country of Birth: _______________ Marital Status: _________________

Who is your support network? ______________________________

Who may we release your information to?

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Tobacco Use (Check boxes accordingly):

☐ No/Never smoked ☐ Yes ☐ Former Smoker: Age Quit; ________

	Tobacco type:	Check if use daily	How much/often per day?	Years used	Age started
	Cigarettes				
	Cigars				
	Chew				
	Smokeless				
	E-Cigarette				
	Other:				

Alcohol Use:

Do you drink alcohol: Yes No If so what kind: ___________________________________

How often: Daily Weekly Monthly Rarely Socially Yearly

How much: ___________________________ When was your last drink: _________________________

Substance Abuse:

Have you or do you currently use illegal drugs? Yes or No

If so, please specify type: _______________________

Sexual History:

Are you sexually active (oral, anal, or vaginal): Yes or No

If so, do you have sex with males, females or both: _______________________

Protected or Unprotected: ________________________