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Patient Demographics

Patient's Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Gender F M

Address _____ Apt. # _____ City _____ State _____ Zip _____

Race:

American Indian/Alaska Native
Black/African American
□ Asian
□ Native Hawaiian/Pacific Islander
□ White
□ Decline to Answer

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Decline to Answer Preferred Language: _____

Marital Status: □ Single □Married □ Divorced □Widowed □Separated Student Status □FT □PT

Home Phone _____ Day Phone _____

Email Address _____ Cell Phone _____

Employer _____ Occupation _____ □Retired?

Employer Address _____

Emergency Contact _____/_____ Phone _____
Name Relationship

Primary Care Physician Name: _____
Phone:_____

Referring Physician Name: _____ Phone:
_____

Pharmacy Name: _____ Phone:
_____

Pharmacy Address:
_____

Primary Insurance Coverage:
_____

Policy Holder Name: _____ SSN:_____
DOB:_____

Secondary Insurance Coverage:
_____

Policy Holder Name: _____ SSN: _____ DOB:
_____

This visit is covered by: □ No Fault Insurance □ Workers' Compensation
_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature _____
Date_____

Responsible Party Name _____ Relationship
_____

Patient History Form

Name: _____ Date of Birth: _____
Reason for Visit: _____
_____

Please List All Current Medications □ **Not Currently Taking Any Medications**

Medication Name
Dosage
How Often Taking
Medication Name
Dosage
How Often Taking

Allergies (e.g. medication, latex, egg) □ **No Known Allergies**

Allergen
Type of Reaction
Allergen
Type of Reaction

Review of Systems

CONSTITUTIONAL

□ No
□ Yes

Chills

□ No
□ Yes

Cough

□ No
□ Yes

Painful Urination

□ No
□ Yes

Fatigue

□ No
□ Yes

Shortness of Breath

□ No
□ Yes

Urinary Frequency

□ No
□ Yes

Fever

□ No
□ Yes

Coughing Blood

□ No
□ Yes

Urinary Incontinence

□ No
□ Yes

Night Sweats

□ No
□ Yes

Wheezing

□ No
□ Yes

Decreased Stream

□ No
□ Yes

Weight Gain

RESPIRATORY

GENITOURINARY

CARDIOVASCULAR

□ No
□ Yes

Urination at Night
□ No
□ Yes
Weight Loss
□ No
□ Yes
Swollen Ankles/Feet

REPRODUCTIVE
HEENT

□ No
□ Yes
Palpitations
□ No
□ Yes
Impotence
□ No
□ Yes
Ear Pain
□ No
□ Yes
Fainting
□ No
□ Yes
Hot Flashes
□ No
□ Yes
Eye Pain
□ No
□ Yes
Leg Cramps Walking
□ No

□ Yes

Decreased Libido
□ No
□ Yes
Hearing Loss

GASTROINTESTINAL
ENDOCRINE

□ No
□ Yes
Nasal Drainage
□ No
□ Yes
Abdominal Pain
□ No
□ Yes
Cold Intolerance
□ No
□ Yes
Sinus Pressure

□ No
□ Yes
Blood in Stools
□ No
□ Yes
Heat Intolerance
□ No
□ Yes
Sore Throat
□ No
□ Yes
Constipation
□ No
□ Yes
Excessive Thirst
□ No
□ Yes
Double Vision
□ No
□ Yes
Diarrhea
□ No
□ Yes
Goiter
□ No
□ Yes
Blurred Vision
□ No
□ Yes
Heartburn

NEUROLOGICAL

□ No
□ Yes
Ringing in Ears
□ No
□ Yes
Nausea
□ No
□ Yes
Dizziness
□ No
□ Yes
Nose Bleeds
□ No
□ Yes
Vomiting

IMMUNOLOGIC

□ No
□ Yes
Difficulty Swallowing

□ No
□ Yes
Change in Bowel Habits

Allergies:
□ No
□ Yes
Hoarseness
□ No
□ Yes
Jaundice
□ No
□ Yes
Hay Fever
□ No
□ Yes
Mouth Sores
□ No
□ Yes
Rectal Bleeding
□ No
□ Yes
Environmental

□ No
□ Yes
Seasonal

□ No
□ Yes
Milk/Lactose

□ No
□ Yes
Other Food
Patient Name: _____ Date of Birth: _____

Past Medical History

Medical Problem
Date of Diagnosis or
Age of Onset

Medical Problem
Date of Diagnosis or Age of Onset

☐
Anemia

☐
Depression

☐
Asthma

☐
Diabetes

☐
Congestive Heart Failure

☐
High Cholesterol

☐
COPD

☐
High Triglycerides

☐
Cancer (current or history of)

☐
Hepatitis

Location(s):

☐
High Blood Pressure

☐
Sarcoidosis

□
Sleep Apnea

□
Tuberculosis

□
GERD

□
Kidney Disease

□
Heart Disease

□
HIV

Other Medical History:

Past Surgical History

Please list all past surgical procedures: □ **No Surgical History**

Surgical Procedure
Year
Surgeon

Family History

□ None □ Unknown/Adopted

Father
Mother
Sister(s)
Brother(s)
Children

Alive?
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
Age at death:
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
Blood Disease
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
Cancer
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
What Type?

Diabetes
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
High Cholesterol
□ Yes □ No
□ Yes □ No

□ Yes □ No
□ Yes □ No
□ Yes □ No
High Blood Pressure
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
Obesity
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
Stroke
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
Peripheral Vascular Disease (PVD)
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
Heart Disease
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No
□ Yes □ No

Patient Name: _____ Date of Birth: _____

Social History

Smoking Tobacco Use History (all patients age 13 and older):
If there is a history of tobacco use:
Years Used: _____
Usage Per Day:_____
Age Stopped:_____
□ Never Smoker
□ Current Every Day Smoker

□ Former Smoker
□ Current Some Day Smoker

□ Unknown if Ever Smoker

□ Smoker Current Status Unknown

Occupation: _____

Please list any hazardous substance exposure (e.g. asbestos):
_____
Do You Consume Alcohol? □ No □ Yes □Former Frequency: _____ Amount:
_____

Do You Consume Caffeine? □ No □ Yes Type: _____ Caffeine per day:
_____

Fall Risk:
Have you fallen in the last 30 days? □ Yes □ No If Yes, please state the number of falls: _____
Did the fall(s) result in injury? □ Yes □ No

Do you use any assistive devices (cane/walker etc.)? If yes, please list

_____
Do you feel like you need assistance with walking today? □ Yes □ No

Safety:
"Recently have you felt physically/emotionally harmed?" □ Yes □ No

Advance Directives:
Do you have any Advance Directive documents? □ Yes □ No
(e.g. living will, power of attorney, do not resuscitate (DNR) orders)

Patient Name: _____ Date of Birth: _____

Please indicate (circle) your current pain scale in relation to your current condition:

How would you prefer that we contact you?
□ Home Phone □ Cell Phone □ Work/Day Phone □ Patient Portal
□ Home Address □ Other _____

Cardiologist's Name: _____ Phone: _____

Endocrinologist's Name: _____ Phone: _____

Gastroenterologist's Name: _____ Phone: _____

Pulmonologist's Name: _____ Phone: _____

Radiation Oncologist's Name: _____ Phone: _____

Medical Oncologist's Name: _____ Phone: _____

Patient Signature: _____ Date: _____

Patient Representative Signature:_____ Relationship: _____