



## Patient Information

**Welcome!** This questionnaire collects information about your **current state of health** to assist the doctors with your care and help them meet requirements established by Medicare and other insurers. This information and your signature will be stored electronically and reformatted for your medical record.

Answer **ALL** questions by filling in the appropriate circle(s) and/or by **PRINTING** the requested information in the appropriate box.

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  Married  Single

Home Phone: (\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_

Home address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship)

(\_\_\_\_) \_\_\_\_\_  
(Emergency Telephone)

E-mail: \_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ (Name) \_\_\_\_\_ (City and/or phone #)

*Permission is granted to text or email appointment reminders unless indicated:*

No text or email appointment reminders

### Health Care Insurance Information:

\_\_\_\_\_  
Primary Health Insurance Carrier Insured Name Date of Birth

\_\_\_\_\_  
Secondary Health Insurance Carrier Insured Name Date of Birth

\_\_\_\_\_  
Employer Address City/State/ZIP (\_\_\_\_) \_\_\_\_\_  
Employer Phone

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

**Allergies**

Are there medications to which you have had an allergic reaction or unpleasant side effects?

- No       Yes →      If yes, please describe in space below.  
If more space is needed, bring a list to your appointment.

Name of Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

- Have you had a reaction to any of the following?       No allergy to any of these or other items
- Adhesive Tape     Iodine or X-ray contrast     Soaps/Detergents
- Fragrance           Latex or rubber                       Other \_\_\_\_\_

Do you have any food allergies?     No     Yes → Bring a list to your appointment.

**Medications**

Please list any prescription and/or non-prescription medications ***including*** vitamins, nutritional supplements, oral contraceptives, pain relievers, laxatives, herbal therapy and cold medications you are currently taking.

- I am not taking any medications

Name of Medication	Dose (Strength)	How Often Taken (Ex. twice daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Have you taken aspirin-containing products in the last two weeks?       No     Yes
- Do you take antibiotics prior to dental work or any other procedure?       No     Yes

## Past Medical History

Have you traveled outside the United States or Canada in the past 6 months?     No     Yes

Have you ever been diagnosed with any of the following infectious diseases?

- |                                    |                          |                           |
|------------------------------------|--------------------------|---------------------------|
| Hepatitis A                        | <input type="radio"/> No | <input type="radio"/> Yes |
| Hepatitis B                        | <input type="radio"/> No | <input type="radio"/> Yes |
| Hepatitis C                        | <input type="radio"/> No | <input type="radio"/> Yes |
| Varicella (chickenpox or shingles) | <input type="radio"/> No | <input type="radio"/> Yes |
| Human Immunodeficiency Virus       | <input type="radio"/> No | <input type="radio"/> Yes |
| Lyme Disease                       | <input type="radio"/> No | <input type="radio"/> Yes |
| Mononucleosis (Epstein-Barr Virus) | <input type="radio"/> No | <input type="radio"/> Yes |
| Tuberculosis                       | <input type="radio"/> No | <input type="radio"/> Yes |
| Resistant Staph Infection (MRSA)   | <input type="radio"/> No | <input type="radio"/> Yes |

Indicate if you have ever sought medical care or had a **medical problem** or **surgery** related to the following:

*The interviewing Nurse will record the dates of diagnosis/surgery, if known.*

- |   |  |  |
|---|--|--|
| <input type="radio"/> Anemia/ Leukemia              | <input type="radio"/> Genetic disorder               | <input type="radio"/> Lung/Pulmonary disorder          |
| <input type="radio"/> Artery or Vein problems       | <input type="radio"/> Glaucoma                       | <input type="radio"/> Lymph gland disorders/Lymphoma   |
| <input type="radio"/> Bladder                       | <input type="radio"/> Graft or transplant            | <input type="radio"/> Muscle weakness                  |
| <input type="radio"/> Blood clots/clotting disorder | <input type="radio"/> Heart/Valve problems           | <input type="radio"/> Neurologic disorder              |
| <input type="radio"/> Bone Disorder/Osteoporosis    | <input type="radio"/> High Blood Pressure            | <input type="radio"/> Pancreatitis                     |
| <input type="radio"/> Bowel/Intestine disorder      | <input type="radio"/> High cholesterol/triglycerides | <input type="radio"/> Psoriasis                        |
| <input type="radio"/> Brain cancer/disorder         | <input type="radio"/> Hormone Disorders              | <input type="radio"/> Psychiatric illness              |
| <input type="radio"/> Breast cancer                 | <input type="radio"/> Joints/Rheumatoid Arthritis    | <input type="radio"/> Skin Cancer → Type: _____        |
| <input type="radio"/> Depression                    | <input type="radio"/> Kidney disease/stones          | <input type="radio"/> Stomach/Ulcer/Digestive Problems |
| <input type="radio"/> Diabetes/Hypoglycemia         | <input type="radio"/> Liver disease                  | <input type="radio"/> Stroke                           |
| <input type="radio"/> Eczema                        | <input type="radio"/> Lupus/Autoimmune disorder      | <input type="radio"/> Thyroid or Parathyroid disorder  |

- Females:**    Might you be pregnant at this time?     No     Yes
- Are you able to get pregnant? (E.g. Hysterectomy/Menopause)     No     Yes
- Are you currently breast-feeding?     No     Yes
- Have your menstrual periods become irregular/abnormal?     No     Yes

**\*\* Please inform the nurse if you feel that you have any other pertinent medical information not listed above \*\***

## Family History

**If known**, fill in the appropriate circles to identify the condition that has occurred in your blood relatives.

***In the space beside the condition →Specify:*** P= "Parent", S= "Sister", B= "Brother", GP= "Grandparent"

Indicate "NONE" if you are unsure or do not know →  None

- |  |   |   |
|--|---|---|
| <input type="radio"/> Allergies/Hives          | <input type="radio"/> Diabetes            | <input type="radio"/> Psoriasis                 |
| <input type="radio"/> Anemia                   | <input type="radio"/> Eczema              | <input type="radio"/> Rheumatoid Arthritis      |
| <input type="radio"/> Anesthesia Complications | <input type="radio"/> Heart disease       | <input type="radio"/> Seizures                  |
| <input type="radio"/> Arthritis                | <input type="radio"/> High blood pressure | <input type="radio"/> Skin cancer Type: _____   |
| <input type="radio"/> Breast Cancer            | <input type="radio"/> Liver disease       | <input type="radio"/> Stomach ulcers            |
| <input type="radio"/> Clotting disorder        | <input type="radio"/> Lung Cancer         | <input type="radio"/> Stroke                    |
| <input type="radio"/> Depression               | <input type="radio"/> Lupus               | <input type="radio"/> Other Psychiatric Illness |
| <input type="radio"/> Other Cancer: _____      |   |   |
| <input type="radio"/> Other Condition: _____   |   |   |

## Social History

- |                                 |                          |                           |
|---------------------------------|--------------------------|---------------------------|
| Do you smoke?                   | <input type="radio"/> No | <input type="radio"/> Yes |
| Do you drink alcohol regularly? | <input type="radio"/> No | <input type="radio"/> Yes |
| Do you use illicit drugs?       | <input type="radio"/> No | <input type="radio"/> Yes |

## Systems Review

Fill in the circle to the left of each symptom that you are currently experiencing. Indicate "NONE" if you are not experiencing any of the symptoms in each group.

- |  |   |   |
|--|---|---|
| <input type="radio"/> Arms/ Legs weakness      | <input type="radio"/> Exposure to tuberculosis (TB)   | <input type="radio"/> Seizures                          |
| <input type="radio"/> Change in bowel function | <input type="radio"/> Fever within the last two weeks | <input type="radio"/> Shortness of breath               |
| <input type="radio"/> Chest pain/pressure      | <input type="radio"/> Headaches                       | <input type="radio"/> Sinus problems                    |
| <input type="radio"/> Coughing                 | <input type="radio"/> Itching/Burning skin            | <input type="radio"/> Swelling feet                     |
| <input type="radio"/> Difficulty urinating     | <input type="radio"/> Joint pain/swelling             | <input type="radio"/> Suicidal thoughts                 |
| <input type="radio"/> Dizziness                | <input type="radio"/> Muscle pain/stiffness           | <input type="radio"/> Weight gain/loss (10 lbs or more) |
| <input type="radio"/> Excessive bruising       | <input type="radio"/> Nausea/vomiting                 | <input type="radio"/> Wheezing                          |
| <input type="radio"/> Excessive thirst         | <input type="radio"/> Numbness in hands/arms/legs     | <input type="radio"/> Unusual sadness/ nervousness      |
|  |   | <b><input type="radio"/> None/ No Symptoms</b>          |

***BRING ANY ADDITIONAL INFORMATION THAT YOU FEEL  
IS RELEVANT FOR THE DOCTOR  
Turn this form in at the front desk when it is complete***