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: O Married O Single

Home Phone: (___)________________ Work Phone: (____)______________ Mobile: (____)_______________

Address: ___________________________________ City/State/ZIP: ___________________________________

Emergency Contact: __________________________________ __________________________________
(Name) (Relationship)

(_____)____________________________ (_____)_____________________________
(Home telephone) (Work / mobile 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	Employer
Secondary Health Insurance Carrier	Insured Name	Date of Birth	Employer

REASON FOR TODAY'S VISIT: ____

Allergies

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

O No   O 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?   O No allergy to any of these or other items

O Adhesive Tape   O Iodine or X-ray contrast   O Soaps/Detergents

O Fragrance   O Latex or rubber   O Other ____________________

Do you have any food allergies?   O No   O 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.

O 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?   O No   O Yes

Do you take antibiotics prior to dental work or any other procedure?   O No   O Yes

Past Medical History

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

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

Hepatitis A	O No	O Yes
Hepatitis B	O No	O Yes
Hepatitis C	O No	O Yes
Varicella (chickenpox or shingles)	O No	O Yes
Human Immunodeficiency Virus	O No	O Yes
Lyme Disease	O No	O Yes
Mononucleosis (Epstein-Barr Virus)	O No	O Yes
Tuberculosis	O No	O Yes
Resistant Staph Infection (MRSA)	O No	O 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.

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

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

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

Family History

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

In the space beside the condition →<u>Specify:</u> P= “Parent”, S= “Sister”, B= ”Brother”, GP= “Grandparent”

Indicate “NONE” if you are unsure or do not know → O None

O Allergies/Hives
O Anemia
O Anesthesia Complications
O Arthritis
O Breast Cancer
O Clotting disorder
O Depression
O Diabetes
O Eczema
O Heart disease
O High blood pressure
O Liver disease
O Lung Cancer
O Lupus
O Psoriasis
O Rheumatoid Arthritis
O Seizures
O Skin cancer Type: ___________________
O Stomach ulcers
O Stroke
O Other Psychiatric Illness
O Other Cancer: ____
O Other Condition: ____

Social History

Do you smoke?	O No	O Yes
Do you drink alcohol regularly?	O No	O Yes
Do you use illicit drugs?	O No	O 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.

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

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