

PATIENT INFORMATION: (PLEASE PRINT)

LAST NAME _____ FIRST NAME _____ MI _____

SEX: MALE FEMALE BIRTH DATE ____/____/____

ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY _____

HOME PHONE: (____) _____ - _____ SOCIAL SECURITY: _____ - _____ - _____

CELL PHONE: (____) _____ - _____ EMAIL ADDRESS: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO DECLINE TO SPECIFY

PRIMARY RACE: WHITE AFRICAN AMERICAN AMERICAN-INDIAN OR ALASKAN NATIVE

ASIAN DECLINE TO SPECIFY UNKNOWN OTHER _____

ENGLISH PROFICIENCY: WELL NOT WELL PREFERRED LANGUAGE: _____

EMPLOYER: _____ WORK PHONE: (____) _____ - _____

EMPLOYMENT STATUS: FULL-TIME PART-TIME RETIRED OCCUPATION _____

INSURANCE / PAYMENT INFORMATION: (Circle one): INSURANCE CASH CHECK

PRIMARY INSURANCE:

PLAN NAME: _____ NAME OF INSURED: _____ DOB _____

GROUP #: _____ MEMBER ID / POLICY # _____

INSURED'S RELATIONSHIP TO PATIENT _____ PHONE # (____) _____ - _____

SECONDARY

PLAN NAME: _____ NAME OF INSURED: _____ DOB _____

GROUP #: _____ MEMBER ID / POLICY # _____

INSURED'S RELATIONSHIP TO PATIENT _____ PHONE # (____) _____ - _____

EMERGENCY CONTACT

RELATIONSHIP TO PATIENT

LAST NAME _____ FIRST NAME _____

ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ - _____ WORK PHONE (____) _____ - _____

PRIMARY CARE PHYSICIAN (PCP) OR FAMILY DOCTOR

ADDRESS _____ PHONE (____) _____ - _____

IF APPLICABLE, THE NAME OF THE DOCTOR WHO REFERRED YOU

ADDRESS _____ PHONE (____) _____ - _____

REASON FOR TODAY'S VISIT _____

Medical History Questionnaire

Patient _____ Date of Birth _____

Instructions:

- Please complete the form below
- This form will be used to screen any conditions that you may have

CONDITIONS: Circle YES or NO as applicable

Condition	If yes, please describe in next column.	Description/Comment	Start date	Ongoing? Is condition still present? Circle YES or NO below.	Stop date - If condition no longer exists, give stop-date.
Kidney Disease	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Diabetes	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
High Blood Pressure	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Ischemic Heart Disease/ Heart problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Cancer	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Stroke	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Gout	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
ENT- Head/Ear/ Nose/ Eye/ Throat/ Mouth problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Cardiovascular- High Cholesterol/ Pacemaker/Valvular heart disease	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Respiratory- Pneumonia/ COPD/ lung problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Gastrointestinal- liver/ hepatitis/ stomach problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /

Medical History Questionnaire

Patient _____

Date of Birth _____

CONDITIONS: Circle YES or NO as applicable

Condition	If yes, please describe in next column.		Description/Comment	Start date	Ongoing? Is condition still present? Circle YES or NO below.		Stop date - If condition no longer exists, give stop-date.
	Yes	No			Yes	No	
Genitourinary- UTI/ Kidney Stones	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Musculoskeletal- Arthritis/ rheumatism/ Osteoporosis	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Neurological- Epilepsy, Seizures, Dementia problems	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Psychiatric- Depression/ Anxiety Disorders	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Endocrine- Hypothyroidism/ Hyperparathyroidism	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Hematology- Anemia/ Blood disease	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Immuno/Allergy- HIV AIDS/ LUPUS	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Prostate problems	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /
Others	Yes	No		/ /	Yes	No	/ /
				/ /	Yes	No	/ /
				/ /	Yes	No	/ /

SURGERIES / HOSPITALIZATIONS:

None

Date	Surgery and Hospitalizations
/ /	
/ /	
/ /	
/ /	
/ /	
/ /	

SOCIAL HISTORY

Tobacco	Alcohol	Caffeine
___ Never Used ___ Ex-user ___ Currently use	___ Never Used ___ Ex-user ___ Currently use	___ Never Used ___ Ex-user ___ Currently use
Start date ____/____/_____ Stop date ____/____/_____ 	Start date ____/____/_____ Stop date ____/____/_____ 	Start date ____/____/_____ Stop date ____/____/_____

# cigarette Packs / day _____ # cigars / day _____ # pipefuls / day _____ # patches / day _____	Beer: # cans / week _____ Wine: # glasses / week _____ Liquor: # drinks / week _____	# ounces / day _____
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DRUG USE

Never used Ex-user

Have you used illicit or recreational drugs in the past 12 months?
 ___ No ___ Yes If yes, date last used: ___/___/___

Is there a Family history of:

Kidney Disease? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
Diabetes? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
High Blood Pressure? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
Ischemic Heart Disease? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
Cancer? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
Stroke? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
Gout? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
ADPKD?(adult polycystic kidney disease) <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child
Dementia? <input type="checkbox"/> None	<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Sibling <input type="checkbox"/> Child

Status:

Father: Living Deceased Unknown Age of Death: _____ Cause of Death: _____

Mother: Living Deceased Unknown Age of Death: _____ Cause of Death: _____

MEDICATIONS: What over-the-counter, herbal remedies or prescription medication do you take? Or None

Medication	Dose	# times/day	Reason	Start Date	Ongoing? Are you still taking this medication?)	Stop date (If not, when did you stop?)
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /

Pharmacy Name/ Location: _____ Pharmacy Phone Number: _____



Patient Name: _____ **DOB :** _____

QUESTIONNAIRE

- Do you have an Advance Care Plan set for end-of-life decisions such as a living will or Power-of -Attorney?
 YES NO

if YES; please provide name of surrogate decision maker: _____
(If you have a copy of the Power of Attorney please provide a copy to our staff.)

- Would you like a General Information form of Durable Power of Attorney? YES NO

- In the past year, has another doctor checked your blood for Lipids (cholesterol)?
 YES NO
if YES; please provide name of doctor _____

- This only applies to diabetic patients: has another doctor checked you blood for A1c? YES NO
if YES; please provide name of doctor _____

- Have you received a flu shot? (seasonal October 1- March 31)
 YES NO
if YES; please provide when and where (provider name or facility) _____

- When was the last time you received the Pneumococcal Vaccine? _____

- If you would like patient electronic access, please provide an email address: _____
(you only have 3 days from date of appointment to activate patient portal)



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HIPAA Release Form

Patient: _____ Date of Birth: _____

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

I do not authorize the information to be released to anyone.

MESSAGES

Please call: my home my work my mobile number: _____

If unable to reach me: you may leave a detailed message

please leave a message asking me to return your call

I am fully aware that a cell phone is not a secure and private line.

Signed: _____

Date: _____