**New Patient Registration – Medical History**

Today’s date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_

Last Name: First Name: \_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male ☐ Female ☐

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apt#: \_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Relationship: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company: ID #: Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance guarantor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Providers/customer service phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: ID #: Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance guarantor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Providers/customer service phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/We do herby consent to authorize the performance of all treatments and medical services deemed advisable by the physicians and staff of Noble Physicians to me. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself regardless of insurance coverage, excluding only authorized services provided under valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys’ fees incurred to collect any amount I may owe. I also hereby authorize Noble Physicians to release information requested by insurance company and/or representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Responsible party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient/Responsible party (please print) Date

**Pharmacy Information**

Preferred Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy phone no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug allergies – Environmental allergies – NO KNOWN ALLERGIES ☐**

Allergy:Mild ☐ \_\_ Moderate ☐ Severe ☐

Allergy:Mild ☐ \_\_ Moderate ☐ Severe ☐

Allergy:Mild ☐ \_\_ Moderate ☐ Severe ☐

**Medications – List all medications you take, prescription and non-prescription, and the dosage:**

Medication: Dose: Last filled:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: Dose: Last filled:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: Dose: Last filled:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: Dose: Last filled:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care – Name & Facility of Primary Care Physician or your previous primary care physician**

Primary Care Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_

Phone no.: \_\_\_\_\_\_ Fax no.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race**

☐ White ☐ Hispanic/Latino ☐ African America ☐ Asian  Native American/Pacific Islander\_

**Marital Status**

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Life Partner  Long term relationship\_\_\_

**Social History – Please explain**

How many partners have you had in this past year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Do you feel safe in your relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Are you sexually active? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Has sex with a person of the same gender? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes ☐ No ☐

Have you ever been diagnosed with an STD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Do you practice birth control? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Do you have any children?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

How many?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do the children reside with you? Yes ☐ No ☐

Male children, female children or both? Ages of the children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have family that lives nearby?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes ☐ No ☐

**Have you ever been abused? Please explain**

Physically abused: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Sexually abused: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Verbally abused: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Emotionally abused: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

**Legal History – Please explain**

DUI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alcohol related ☐ Drug related ☐ No ☐

Domestic Violence: Yes ☐ No ☐

Other: Yes ☐ No ☐

**Personal Safety**

Do you keep firm arms in your home? Yes ☐ No ☐ Do you keep them in a safe place? Yes ☐ No ☐

Do you wear a seat belt while driving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

**Tobacco, Alcohol, Caffeine and Exercise**

Do you smoke cigarettes?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Chewing tobacco?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

How many cigarettes do you smoke daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

How many drinks do you have a day/week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beer Yes ☐ No ☐ \_\_ Liquor Yes ☐ No ☐ Wine Yes ☐ No ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coffee Yes ☐ No ☐ \_\_\_\_\_\_\_\_\_\_\_Tea Yes ☐ No ☐ \_\_\_\_\_\_\_Energy drinks Yes ☐ No ☐\_\_\_\_\_\_\_\_

Do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

**Level of Education**

High school graduate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Obtained GED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes ☐ No ☐

College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

Vocation school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

**Check if you have had any of the following immunizations – Please specify when last received**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Vaccine** | **Yes** | **No** | **I don’t know** | **Last Received** |
| Influenza |  |  |  |  |
| Pneumonia |  |  |  |  |
| Tetanus |  |  |  |  |
| BCG |  |  |  |  |
| MMR (measles, mumps, rubella) |  |  |  |  |
| HPV |  |  |  |  |
| Hepatitis B |  |  |  |  |

**Substance Abuse History – Check all that apply. Please indicate the route of use and age when use started**

|  |  |  |
| --- | --- | --- |
| Alcohol | ☐ Oral | ☐ Other |
| LSD/ACID | ☐ Oral | ☐ Other |
| Heroin | ☐ Smoke | ☐ Intravenous |
| Anti-Anxiety Medications | ☐ Oral | ☐ Other |
| Marijuana | ☐ Smoke | ☐ Ingest |
| Barbiturates | ☐ Oral | ☐ Other |
| Methamphetamine/Amphetamine/Crystal Meth | ☐ Smoke | ☐ Intravenous |
| Cocaine | ☐ Snort | ☐ Smoke |
| Pain Killers, Oxycodone, OxyContin, Vicodin, etc. | ☐ Smoke | ☐ Intravenous ☐ Other |

How long has it been since you’ve last used any illicit drugs (in recent time)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been misusing substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced an over dose? (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health Provider – Please name**

Name of counselor & facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor phone no.: Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of psychiatrist & facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist phone no.: Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you attend Narcotics Anonymous meetings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_­­ Yes ☐ No ☐

Do you have a sponsor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes ☐ No ☐

**Opioid Withdrawals – Please check**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Muscle Aches | ☐ No | ☐ Yes | Runny nose | ☐ No | ☐ Yes |
| Restlessness | ☐ No | ☐ Yes | Excessive sweating | ☐ No | ☐ Yes |
| Anxiety | ☐ No | ☐ Yes | Sleeplessness | ☐ No | ☐ Yes |
| Tearing eyes | ☐ No | ☐ Yes | Excessive yawning | ☐ No | ☐ Yes |
| Diarrhea | ☐ No | ☐ Yes | Abdominal cramps | ☐ No | ☐ Yes |
| Nausea and vomiting | ☐ No | ☐ Yes | Dilated pupils | ☐ No | ☐ Yes |
| Rapid heartbeat | ☐ No | ☐ Yes | Other | | |

**Substance Abuse History – Self Assessment**

|  |  |  |
| --- | --- | --- |
| Do you abuse more than one (1) drug at a time? | ☐ No | ☐ Yes |
| Are you unable to stop using drugs when you want to? | ☐ No | ☐ Yes |
| Have you ever had black outs or flashbacks because of drug use? | ☐ No | ☐ Yes |
| Do you ever feel bad or guilty about your drug use? | ☐ No | ☐ Yes |
| Does your spouse, family or friends know of your involvement with drugs? | ☐ No | ☐ Yes |
| Have you engaged in illegal activities because of your drug use? | ☐ No | ☐ Yes |
| Have you ever experienced withdrawal symptoms when not taking drugs? | ☐No | ☐ Yes |
| Have you had any medical problems because of your drug use? | ☐No | ☐ Yes |
| Have you performed sexual favors for money or drugs? | ☐ No | ☐ Yes |

**PHQ – Depression Screening**

Over the last two weeks how often have you been bothered by any of the following problems?

For each question, select the option that best describes the amount of time you felt that way.

**In the past 2 weeks Not at all – Several days – Nearly everyday**

1. Little interest/please in doing things ☐ ☐ ☐
2. Feeling down, depressed or hopeless ☐ ☐ ☐
3. Trouble falling/staying asleep or sleeping too much ☐ ☐ ☐
4. Feeling tired or having little energy ☐ ☐ ☐
5. Poor appetite or over eating ☐ ☐ ☐
6. Feeling bad about yourself or feeling like a failure ☐ ☐ ☐
7. Moving or speaking slowly that other could have noticed or being fidgety or restless that you have been around more than usual ☐ ☐ ☐
8. Thoughts that you’d be better off dead or thoughts of hurting your self

☐ ☐ ☐

**Medical History – Check if you have ever experienced the following conditions, and year or onset**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Year** | **Condition** | **Year** |
| ☐ None |  | ☐ Gallbladder Disease |  |
| ☐ Allergies |  | ☐ GERD (Reflux) |  |
| ☐ Anemia |  | ☐ Hepatitis C |  |
| ☐ Angina |  | ☐ Hyperlipidemia |  |
| ☐ Anxiety |  | ☐ Hypertension |  |
| ☐ Arthritis |  | ☐ Irritable Bowel Disease |  |
| ☐ Asthma |  | ☐ Liver Disease |  |
| ☐ Atrial Fibrillation |  | ☐ Migraine Headaches |  |
| ☐ Benign Prostatic Hypertrophy |  | ☐ Myocardial Infarction |  |
| ☐ Blood Clots |  | ☐ Osteoarthritis |  |
| ☐ Cancer – Type |  | ☐ Osteoporosis |  |
| ☐ Cerebrovascular Accident |  | ☐ Peptic Ulcer |  |
| ☐ Coronary Artery Disease |  | ☐ Renal Disease |  |
| ☐ CODP (Emphysema) |  | ☐ Seizure Disorder |  |
| ☐ Crohn’s Disease |  | ☐ Thyroid Disease |  |
| ☐ Depression |  | ☐ Diabetes |  |

**Surgical History – Check if you have received the following procedures, and year performed**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surgical Procedure** | **Year** | **Surgical Procedure** | **Year** |
| ☐ None |  | **Male Only** |  |
| ☐ Angioplasty |  | ☐ Prostate Biopsy |  |
| ☐ Angioplasty w/stent |  | ☐ TURP (trans-Urethral Resection of Prostate |  |
| ☐ Appendectomy |  | ☐ Vasectomy |  |
| ☐ Arthroscopy |  | ☐ Other |  |
| ☐ Back Surgery |  | ☐ Other |  |
| ☐ CABG (Heart Bypass) |  |  |  |
| ☐ Carpal Tunnel Release |  | **Female Only** |  |
| ☐ Cataract Extraction |  | ☐ Augmentation Mammoplasty |  |
| ☐ Cholecystectomy |  | ☐ Bilateral Tubal Ligation |  |
| ☐ Colectomy |  | ☐ Breast Biopsy |  |
| ☐ Colostomy |  | ☐ Cesarean Section |  |
| ☐ Gastric Bypass |  | ☐ D and C |  |
| ☐ Hernia Repair |  | ☐ Hysterectomy |  |
| ☐ Hip Replacement |  | ☐ Mastectomy |  |
| ☐ LASIK |  | ☐ Myomectomy |  |
| ☐ Liver Biopsy |  | ☐ Reduction Mammoplasty |  |
| ☐ Pacemaker |  | ☐ TAH/BSO |  |
| ☐Pacemaker |  | ☐ Vaginal Hysterectomy |  |
| ☐ Thyroidectomy |  | ☐ Other |  |
| ☐ Tonsillectomy |  | ☐ Small Bowel Resection |  |

**Health Maintenance – Check if you have received the following, and date of most recent exam**

|  |  |  |  |
| --- | --- | --- | --- |
| **Exam** | **Date** | **Exam** | **Date** |
| ☐ None |  | ☐ GYN Exam |  |
| ☐ Breast Exam |  | ☐ Influenza Vaccine |  |
| ☐ Cardiac Stress Test |  | ☐ Lipid Panel |  |
| ☐ Colonoscopy |  | ☐ Mammogram |  |
| ☐ DEXA Exam |  | ☐ PAP Test |  |
| ☐ Echocardiogram |  | ☐ Physical Exam |  |
| ☐ EKG |  | ☐ Pneumococcal Vaccine |  |
| ☐ Eye Exam |  | ☐ Pulmonary Function Test |  |
| ☐ FOBT (Stool Card for Hidden Blood) |  | ☐ Sigmoidoscopy |  |
| ☐ Foot Exam |  | ☐ Tetanus Vaccine |  |
| ☐ Other |  | ☐ Other |  |

**Family History – Check any family member(s) has had any of the following conditions**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **☐ Adopted** | **Check** | **Check** | **Check** | **Check** | **Check** |
| **Diagnosis** | **Mother** | **Father** | **Brother** | **Sister** | **Other** |
| Alcoholism |  |  |  |  |  |
| Alzheimer’s Disease |  | ☐ |  |  |  |
| Asthma |  |  |  |  |  |
| Blood Disease |  |  |  |  |  |
| CAD (Heart Attack) |  |  |  |  |  |
| Cancer – Type: |  |  |  |  |  |
| CVA (Stroke) |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Developmental Delay |  |  |  |  |  |
| Diabetes |  |  |  |  |  |

**Any additional information you would like our office staff or Provider(s) to know about you?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Today’s Date:** | **Follow up date & time:** | | **Return to clinic: Weekly ☐ - Bi-weekly ☐ - Monthly ☐** | **Type of encounter:** |  |  |  |  | | --- | --- | --- | | **Patient’s last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Middle:\_\_\_\_\_\_\_\_\_\_** |  |  |  |  | | --- | --- | --- | | **Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |   **Chief complaint: Drug Allergies:**   |  |  |  | | --- | --- | --- | | **Buprenorphine** | **Morphine** | **Barbiturates** | | **Benzodiazepines** | **Methamphetamines** | **Methadone** | | **(Oxy) Oxycodone** | **Amphetamines** | **Cocaine** | | **Opiates** | **(THC) Cannabinoids** | **Pregnancy:** |  |  |  |  | | --- | --- | --- | | **Prescription:** | **#** | **Hard script** |   **BP: Temp: HR: Oz%: WT: HT:**   |  | | --- | | **Blood work: CBC  – CMP  – BMP  – TSH  - Lipids ☐ - Fasting lipids - ☐ HIV 1&2 ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ICD code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  **Other labs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  |  |  | | --- | --- | --- | | **Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_** | **ICD 10 code:\_\_\_\_\_\_\_ \_\_** | | **Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_** | **ICD 10 code:\_\_\_\_ \_ \_\_\_\_** |   **PMP check:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   |  |  |  | | --- | --- | --- | |  | **Seen by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_** | **Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  | **Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_** | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  | |