Medical Record #: _____

FOR OFFICE USE ONLY

PATIENT INFORMATION FORM

Patient Name: _____

Date of Birth: _____

Previous and/or Maiden Name: _____

Parent/Guardian Name if patient is minor: _____

Birth date: (M/D/Yr) _____ **Gender:** ☐ Male ☐ Female

SSN (patient):_____ **SSN** (guardian, if patient is minor): _____

Address: _____ **City**:_____ **State**: _____ **Zip**: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ **Marital Status:** _Single _Married _Widowed _Divorced

Spouse's Last Name: _____ **First Name**: _____ **Middle Initial**: _____ DOB:_____

Spouse's Employer: _____ **Phone Number:** _____

Language: _English _Spanish _Other: _____

Race: _Caucasian or White _Black or African American _ American Indian _Alaska Native _ Asian _Native Hawaiian _Pacific Islander _Other: _____

Ethnicity: _Hispanic/Latino _Not Hispanic/Latino

EMPLOYMENT

Patient/Parent's Employer: _____ **Phone Number**: _____

Occupation: _____

Been Exposed to Hazardous Materials (ex: asbestos, radiation, TB, etc.)**:** _Yes _No

INSURANCE

Primary Insurance Company: _____

Plan #: _____ Policy Holder: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Secondary Insurance Company:

Plan #: _____ Policy Holder: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Emergency Contact - Individuals with whom we may discuss medical care/authorization for treatment:

Name/Relationship: _____ Phone Number: _____

Name/Relationship: _____ Phone Number: _____

Power of Attorney: _____

Do you have an Advanced Directive? (End of Life Care) _Yes _No

How did you hear about us? _TV/Radio ___Newspaper _Community _Friend/Relative _Social Media _Mailer _Other

_____ _____

Signature of patient or guardian Date

Medical Record #: _____
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NEW PATIENT HISTORY FORM

Patient Name: _____
Date of Birth: _____

Reason for Visit: _____

Primary Care Physician: _____

Referring Physician: _____

Any religious, cultural or spiritual beliefs that may affect your treatment? ☐ Yes ☐ No

If Yes, please explain: _____

PAST MEDICAL HISTORY (Please check all that apply):

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Arial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Clots
- ☐ Cancer (type)
- ☐ CVA (stroke)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Valve Disease
- ☐ Other: _____

PAST SURGICAL HISTORY (Please check all that apply):

- ☐ Angioplasty
- ☐ Angioplasty with Stent
- ☐ Appendectomy
- ☐ Arthroscopy Knee
- ☐ Back Surgery
- ☐ CABG (Heart Bypass
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (Gall Bladder)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Ear Tubes
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Lasik
- ☐ Liver Biopsy
- ☐ Open Reduction & Internal Fixation
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Other: _____

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NEW PATIENT HISTORY FORM

Patient Name: _____
Date of Birth: _____

SOCIAL HISTORY

Special Diet Restrictions: _____

Frequency of Exercise: ☐None/Occasionally ☐1-2 times/week ☐3-5 times/week ☐Every day

Type of Exercise (ex: aerobic, walking, martial arts, etc.)**:** _____

Drug Usage: ☐Never ☐Occasionally ☐Regularly ☐Used in the past – Year Quit:_____

Type of Drug(s) (ex: acid, cocaine, marijuana, etc.): _____

Route of Drug(s) (ex: , inhale, in muscle, oral, etc.): _____

Alcohol Usage: ☐Never ☐Occasionally ☐Regularly ☐Used in the past – Year Quit: _____

Alcohol Type: _____ Drinks Per Week: _____ Years Used: _____

Tobacco Usage: ☐Never ☐Occasionally ☐Regularly ☐Used in the past – Year Quit: _____

Type: _____ Packs/Cans Per Day: _____ Years Used: _____

Exposed to second hand smoke: ☐Yes ☐No

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NEW PATIENT HISTORY FORM

Patient Name: _____
Date of Birth: _____

FAMILY HISTORY (Please check all that apply)**:**

___ ADD/ADHD	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Alcoholism	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Allergies	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Alzheimer's Disease	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Asthma	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Blood Disease	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Breast Cancer	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Colon Cancer	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ CVA (stroke)	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Depression	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Developmental Delay	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Diabetes	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Eczema	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Hearing Deficiency	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Heart Disease	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ High Blood Pressure	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Hyperlipidemia	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Irritable Bowel Disease (IBS)	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Learning Disability	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Mental Illness	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Migraines	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Obesity	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Osteoarthritis	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Prostate Cancer	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ PVD (Blood flow problems: arms, legs, neck)	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Renal Disease	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Seizure Disorder	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____
___ Thyroid Disease	___ Mother	___ Father	___ Brother	___ Sister	___ Other	_____

Other: _____

Medical Record #: _____

FOR OFFICE USE ONLY

MEDICATION & ALLERGIES FORM

Patient Name: _____

Date of Birth: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Location: _____

ALLERGIES

☐ None ☐ Penicillin ☐ Sulfa Drugs ☐ IVP Dye

☐ Food: _____

☐ Other: _____

MEDICATIONS

Name	Dosage	How often taken