

PLEASE PRINT

<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>
<b>SS Number</b>	<b>Date of Birth</b>	<b>Age</b>
<b>Gender</b>	<b>Marital Status</b>	
<b>Address</b>		
<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Student?</b>	<b>Work Status</b>	<b>Email</b>
<b>Home Phone</b>	<b>Work Phone</b>	<b>Cell Phone</b>
<b>Race</b>	<b>Emergency Contact</b>	<b>Emergency Contact Phone</b>
<b>Referred by</b>		

**RESPONSIBLE PARTY**

<b>Self?</b>	<b>Yes/No</b>	<b>(If no, please provide details below)</b>
<b>Relationship to Patient</b>		
<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>
<b>Address</b>		
<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Home Phone</b>	<b>Work Phone</b>	<b>Cell Phone</b>

<b>Do You Have Power of Attorney?</b>	<b>Yes/No (If Yes Please List Info Below)</b>
<b>Name</b>	<b>Phone</b>
<b>Do You Have a Do Not Resuscitate (DNR)?</b>	<b>Yes/No</b>
<b>Do Have a Living Will?</b>	<b>Yes/No</b>
<b>Do you have any special request for the physician regarding end of life care:</b>	

PLEASE PRINT

<b>Primary Insurance</b>		
Carrier Name	Plan Name	Group Number
Relationship of Insured to Patient ( If Self, Please fill in only fields with *)		
Insured First Name	Insured Middle Name	Insured Last Name
Insured ID*	Date of Birth	Gender
Address		
City	State	Zip
Home Phone	Insured's Employer Name	
Coverage Start Date*	Coverage End Date (If applicable)	

<b>Secondary Insurance</b>		
Carrier Name	Plan Name	Group Number
Relationship of Insured to Patient ( If Self, Please fill in only fields with *)		
Insured First Name	Insured Middle Name	Insured Last Name
Insured ID*	Date of Birth	Gender
Address		
City	State	Zip
Home Phone	Insured's Employer Name	
Coverage Start Date*	Coverage End Date (If applicable)	

<b>Tertiary Insurance</b>		
Carrier Name	Plan Name	Group Number
Relationship of Insured to Patient ( If Self, Please fill in only fields with *)		
Insured First Name	Insured Middle Name	Insured Last Name
Insured ID*	Date of Birth	Gender
Address		
City	State	Zip
Home Phone	Insured's Employer Name	
Coverage Start Date*	Coverage End Date (If applicable)	

PLEASE PRINT

**Preventive Screening**

Exam	Date	Results	Exam	Date	Results
Last Physical Exam			Last Mammogram		
Last Eye Exam			Last Breast Exam		
Last Rectal Exam			Last Pap Smear		
Last Stool Occult			Last Sigmoid/Colonoscopy		
Last Pneumonia Shot			Last PPD		
Last PT/INR			If any Abnormal Results Please Explain Treatment:		

**Past Illness History**

Illness Name	Yes	No	Unable to Work?	Result

**Past Surgical History**

Surgery Name	Date	Place, Physician	Complications

**OB/GYN History**

Age of Menstruation	Frequency	Duration	Men. Flow	
Menstrual Pain	Pre-Men Symp	Contraceptives	Last Men Date	
H/O Fibroid	H/O Ovar Cyst	H/O Endometriosis	H/O Cerv Cancer	
Childbirths-When	Where	Mode of Birth	Complications	
Miscarriages-Why	When	Age	Where	Complications

**Current Medical History**

Please List Any Current Medical History You Would Like To Discuss With The Physician

Are you currently under the care of any specialists: Yes/No (if yes please explain)

PLEASE PRINT

### Family & Social History

Do you or your family have any problems with:

	Yes/No	When?		Yes/No	When?
Heart			Auto Immune Disease		
Blood Pressure			Arthritis		
Diabetes			Osteoporosis		
Bleeding Disorder			High Cholesterol		
Cancer			Other:		

**Notes:**

Tobacco Use (Circle One) **None Chews Currently Smoking** Prev Smoked \_\_\_\_\_ packs/day

**Notes:**

Alcohol Use (Circle One) **None Previously Occasional Moderate to Heavy** \_\_\_\_\_ per/day

**Notes:**

Substance Abuse History: **Yes/No**

**Notes**

Marital Status (Circle One) **Married Single Separated Divorced Widowed** \_\_\_\_\_ #Children

Diet Preferences	Pets	Travel History	Religious Preference

### Allergies

Medication	Reaction	Mild	Moderate	Severe

Food & Environmental Allergies	Reaction	Mild	Moderate	Severe

