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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: (Last, First, MI) | | | | | | | | |  |  | | | | |  | | | | |
| Local Address: | | | | |  | | | |  |  | | | | |  | | | | |
| City: | | |  | |  | | | |  | State: | | | | | Zip: | | | | |
| Cell Phone: | | | | |  | | | | Home Phone: | | | | |  | | | | | |
| E-Mail: | | |  | |  | | | |  |  | | | | |  | | | | |
| Social Security #: | | |  | |  | | | |  | Date of Birth: | | | | |  | | | | |
| Primary Pharmacy: | | |  | |  | | | |  |  | | | | |  | | | | |
| Insurance Primary: | | |  | |  | | | |  |  | | | | | Policy/Group #: | | | | |
| Insurance Secondary: | | |  | |  | | | |  |  | | | | | Policy/Group #: | | | | |
| Address Other: | | | | |  | | | |  |  | | | | |  | | | | |
| City: | | |  | |  | | | |  | State: | | | | | Zip: | | | | |
| Cell Phone: | | | | |  | | | | Home Phone: | | | | |  | | | | | |
| E-Mail: | | |  | |  | | | |  |  | | | | |  | | | | |
| Emergency Contact: | | | | | | | | |  |  | | | | |  | | | | |
| Address: | | |  | |  | | | |  |  | | | | |  | | | | |
| City: | | |  | |  | | | |  | State: | | | | | Zip Code: | | | | |
| Cell Phone: | | | | |  | | | | Home Phone: | | | | |  | | | | | |
| E-Mail: | | |  | |  | | | |  |  | | | | |  | | | | |
| People we can release personal health information: | | | | | | | | | | | | | | | | | | | |
|  | | |  | |  | | | |  |  | | | | |  | | | | |
|  | | |  | |  | | | |  |  | | | | |  | | | | |
| Medications: (List name, dosage, times per day taken) | | | | | | | | | | | | | | | | | | | | |
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| Allergies: (List name and reaction if known) | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Alcohol | | |  | | Smoke | | | | | |  | Vaping: | | |  | |  |  |
| Never | | |  | | Never | | | | | |  | # Packs/day | | | # years | | Year quit |  |
| Yes | | |  | | Yes Current | | | | | |  |  | | |  | |  |  |
| Former | | |  | | Former | | | | | |  |  | | |  | |  |  |
| Sexual Orientation: | | |  | |  | | | | | |  |  | | |  | |  |  |
| Marital Status | | |  | | # Children | | | | | |  | Religious Pref: | | | |  |  |  |
| Single | | |  | | Adv Directive: | | | | | |  |  | | |  | |  |  |
| Married | | |  | | Colonoscopy: | | | | | |  |  | | |  | |  |  |
| Divorced | | |  | | Mammogram: | | | | | |  |  | | |  | |  |  |
| Widowed | | |  | | Bone Density: | | | | | |  |  | | |  | |  |  |
| Other | | |  | | GYN Exam: | | | | | |  |  | | |  | |  |  |
| Occupation: | | |  | |  | | | | | |  |  | | |  | |  |  |
| Recreational Drug Use | | |  | | Type: | | | | | |  |  | | |  | |  |  |
| Never | | |  | |  | | | | | |  |  | | |  | |  |  |
| Former | | |  | |  | | | | | |  |  | | |  | |  |  |
| Current | | |  | |  | | | | | |  |  | | |  | |  |  |
| Family Medical History: Check all that apply | | | | | | | | | | | | | | | | | | | | |
|  | | | Alcoholism/Drug Abuse | | | | |  |  | | | Heart Disease | | | | | | | | |
|  | | | Alzheimer's/Dementia | | | | |  |  | | | High Blood Pressure | | | | | | | | |
|  | | | Anxiety | | | | |  |  | | | High Cholesterol | | | | | | | | |
|  | | | Arthritis | | | | |  |  | | | Kidney Disease | | | | | | | | |
|  | | | Asthma/COPD/Emphysema | | | | |  |  | | | Liver/Pancreas | | | | | | | | |
|  | | | Bleeding Disorder | | | | |  |  | | | Lymphoma/Leukemia | | | | | | | | |
|  | | | Bowel/Colon | | | | |  |  | | | Mental Illness | | | | | | | | |
|  | | | Cancer | | | | |  |  | | | Prostate | | | | | | | | |
|  | | | Depression | | | | |  |  | | | Seizures | | | | | | | | |
|  | | | Diabetes | | | | |  |  | | | Stroke | | | | | | | | |
|  | | | Genetic Disease | | | | |  |  | | | Thyroid Disease | | | | | | | | |
|  | | | Gynecological | | | | |  |  | | | Vision | | | | | | | | |
|  | | | Hearing | | | | |  | Other: | | | | | | | | | | | |
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| --- | --- | --- | --- | --- |
| Personal Medical History: Check all that apply | | | |  |
|  | Alcoholism/Substance Abuse |  |  | Lung Dis (Asthma/COPD/Emphysema) |
|  | Allergies |  |  | Lymphoma/Leukemia |
|  | Anemia |  |  | Major Infectious Disease |
|  | Anxiety |  |  | Major Injury |
|  | Arthritis |  |  | Memory/Dementia Illness |
|  | Atrial Fibrillation/Irregular heartbeat |  |  | Mental Illness |
|  | Back Pain |  |  | Migraines/Headache |
|  | Bleeding/Clotting Disorder |  |  | Neuropathy |
|  | Blood Transfusion |  |  | Obesity/Weight Issues |
|  | Bowel/Colon Disease |  |  | Osteoporosis/Osteopenia |
|  | Cancer |  |  | Parkinson's |
|  | Cholesterol |  |  | Periph Artery Dis (aorta/leg/neck/arms) |
|  | Congestive Heart Failure |  |  | Prostate Problem |
|  | Coronary Artery Disease/Heart Attack |  |  | Pulmonary Embolism |
|  | Depression |  |  | Pulmonary hypertension |
|  | Diabetes |  |  | Seizures |
|  | GERD/Ulcers/Stomach |  |  | Sexual Dysfunction |
|  | Gynecological |  |  | Sexually Transmitted Disease |
|  | Hearing |  |  | Sinus |
|  | Heart Disease/Valvular |  |  | Skin/Dermatologic Disorder |
|  | High Blood Sugar |  |  | Sleep Apnea |
|  | HIV/AIDS |  |  | Stroke |
|  | Hypertension/High Blood Pressure |  |  | Thyroid Disease |
|  | Implant/Pacemaker/Defibrillator |  |  | Urinary/Bladder |
|  | Insomnia |  |  | Veins/Blood Clots |
|  | Kidney Disease |  |  | Vision |
|  | Liver/Pancreatic Illness |  | Other: | |
|  |  |  |  |  |
|  |  |  |  |  |
| Surgeries: Type and date | |  |  |  |
|  |  |  |  |  |
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