|  |  |  |  |
| --- | --- | --- | --- |
| 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) |
|   |
|   |
|   |
|  |
|   |
|   |
| 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: |
|   |   |   |   |   |
|   |   |   |   |   |

|  |  |
| --- | --- |
| 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 |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |