# The Family Practice

*Please complete all the areas below if you are a new patient.*
*Please put your name and any changes if you are an established patient.*

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender: Male Female

Marital Status: Single Married Divorced Widowed

Language Preference: _____

Race: White Black Asian Indian/ Alaskan Pacific Isle Other/ Multi

Social Security #: _____ Date of Birth: ____/____/_____

Home #: _____ Work #: _____

Cell #: _____ Employer: _____

Email address: _____ or None

Legal Guardian (if applicable): _____

Emergency Contact — Name: _____ Phone # : _____

Relation: _____

Head of Household: _____ Date of Birth: ____/____/_____

| Other Family Members: | Name | Date of Birth |
|---|---|---|
| | _____ | ____/____/_____ |
| | _____ | ____/____/_____ |
| | _____ | ____/____/_____ |
| | _____ | ____/____/_____ |

## Insurance Information

**(if you have given your ins. card to the front desk, do not fill out this box)**

Insurance Plan: _____ Policy #/Group #: _____/_____

Address to send claims: _____

Copay: _____ Policy Holder's Name: _____

Secondary Ins and Address: _____

_____

## How did you hear about us? (please circle one)

Existing Patient_____

Physician Referral _____

Friend/ Relative _____

Other _____

All patient information is kept confidential and secured. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Patient Signature _____ Date ____/____/_____

Patient Name _____DOB_____

## Past Medical History

***(Circle all that <u>you</u> have or had in past, or write in any not mentioned)***

**Heart/ Blood Vessels:** - High Blood Pressure - Heart Attack
- Heart Failure - Coronary Artery Blockage - Angina Congestive
- TIA (ministroke) - Stroke - Palpitations Heart
- Rhythm Problems (Atrial Fibrillation, etc) - Claudicating
- Heart Murmur - Pacemaker - Aneurysm

**Lung/ Respiratory:** - COPD/ Emphysema - Bronchitis
- Asthma - Pneumonia - Tuberculosis
- Pulmonary Fibrosis - Pulmonary Hypertension

**Neurological (nerves/ brain)** - Headaches– Migraine/ Sinus/ Tension/ Other
- Seizure Disorder - Peripheral Neuropathy

**Ear/ Nose/ Throat:** -Ear Infections - Nasal Polyps
- Sinusitis - Chronic Nasal Congestion - Hearing Loss
- Nasal Allergies

**Eye:** - Glaucoma - Poor Vision
- Macular Degeneration - Iritis

**Stomach/ Liver/ Intestines/ Colon:** - Crohns Disease
- Colitis - Ulcerative Colitis - Hemorrhoids
- Ulcers (stomach/ duodenal) - Reflux/ GERD/ Barrett's - Irritable Bowel Syndrome
- Celiac Disease - Constipation - Milk (lactose) Intolerance
- Diverticulosis - Diverticulitis

**Kidney/ Urinary:** - Kidney Stones - Kidney Failure
- Renal Insufficiency - Blood in Urine - Interstitial Cystitis
- Urinary Tract Infection/ UTI/ Cystitis/ Kidney Infection

**Male Genital:** - Sexual Dysfunction - Prostate Enlargement
- STD (Chlamydia Gonorrhea Herpes Genital Warts etc)

**Gynecologic (female reproductive):** - Abnormal Mammogram
- Breast Lump/ mass/ cyst - Colposcopy - Abnormal Pap Smear
- Pelvic Infection - Infertility - Pelvic Pain
- Ovarian Cysts/ Polycystic Ovarian Disease - Abnormal Bleeding (too much, irregular)
- STD (gonorrhea Chlamydia herpes genital warts etc)
- Sexual Dysfunction

**OB:** Ever Pregnant? Yes No
How many pregnancies? _____ Full Term _____ Preterm _____
Miscarriages/ Abortions _____ How Many Living Children? _____
Vaginal Births # _____ C– Section # _____

| | | |
|---|---|---|
| **Skin:** | - Acne | - Eczema |
| -Psoriasis | - Keloids | - Abnormal Hair Growth |
| - Nail Problems | - Precancerous Growths | |
| **Bone/ Joint:** | - Low Back Pain | - Neck Pain |
| - Sciatica | - Fracture(s) | - Degenerative Arthritis |
| - Plantar Fasciitis/ Heel Pain | - Ankle Sprain | |
| **Blood/ Bleeding:** | - Blood Clots/ Pulmonary Embolus/ Excess Clotting | |
| - Easy Bleeding | - Easy Bruising | |
| **Endocrine (hormones):** | -Diabetes | - Low/ High Thyroid Problems |
| - Graves' Disease | - Cholesterol/ Triglyceride Problems | |
| **Rheumatology:** | - Rheumatoid Arthritis | - Lupus |
| - Sjogrens | - Fibromyalgia | - Chronic Fatigue |
| **Mental Health:** | - Depression | - Anxiety |
| - Panic Attacks | - Post-traumatic Stress Disorder (PTSD) | |
| - Bipolar Disorder | - ADD | - ADHD |
| **Cancer** _____ | treatment received _____ | |
| _____ | treatment received _____ | |
| **Allergy/ Immune System** | | - Nasal Allergies |
| - Bee Allergy | - Immune Deficiency | - Hives/ Urticaria |

| **Past Surgical/ Procedure History** | | **None** |
|---|---|---|
| PET (ear Tubes) | Sinus Surgery | Tonsillectomy |
| Adenoidectomy | Eye Surgery | Brain Surgery |
| Heart Catheterization | Colon Removal | Gall Bladder Removal |
| Nissen Fundolplication (for GERD) | | Hemorrhoid Surgery |
| Hernia Repair | Breast Surgery | Cosmetic Surgery |
| Appendectomy | Spleen Surgery | Kidney Surgery |
| TURP (prostate) | Vasectomy | Tubal Ligation |
| D&C (Dilation & Curettage) | Colposcopy | Cesarean Section |
| Laparoscopy | Ovary Surgery | Arthroscopy |
| Uterus Surgery (hysterectomy or other) | | Spinal Fusion |
| Surgery for Fracture _____ | | Diskectomy |
| Joint Replacement– Hip/ Knee/ Shoulder/ Other | | Laminectomy |

## Preventive Health Screening (please give date)

Mammogram Prostate Exam/ PSA PAP Smear

Colonoscopy/ Flex sig/ Stool Test Tetanus Booster

Pneumovax

Current Medications/ vitamins/ supplements _____

_____

_____

_____

Allergies/ Reactions _____

_____

_____

**Marital Status:** Married Single Widowed Divorced Engaged Significant Relationship

**Occupation:** Unemployed Student Homemaker Retired Work (part/ full)

**Exercise:** Yes No - Aerobics - Resistance How often _____

**Tobacco Use:** Yes No - cigarettes - cigar - pipe - dip/ snuff
Amount per day _____ Interested in stopping? Yes No

**Alcohol Use:** Yes No Drinks per week _____

**Non prescription Drug use:** Yes No

**Religious Preference:** - none -Buddhist -Christian - Hindu -Muslim -other

**Sexually Active:** Yes No Never *if yes*—- Same partner different partners

**Contraception Used**: Yes No *if yes, what kind-* _____

# Family History

(list any past or current medical conditions for the following family members)

**Are you adopted? Y N**

**Father-** Alive Deceased (if deceased due to medical condition, specify) _____

**Mother-** Alive Deceased (if deceased due to medical condition, specify) _____

**Brother(s)-** Alive Deceased(if deceased due to medical condition, specify) _____

**Sister(s)-** Alive Deceased (if deceased due to medical condition, specify) _____

**Paternal Grandfather-** Alive Deceased (if deceased due to medical condition, specify) _____

**Paternal Grandmother-** Alive Deceased (if deceased due to medical condition, specify) _____

**Maternal Grandfather-** Alive Deceased (if deceased due to medical condition, specify)

_____

**Maternal Grandmother-** Alive Deceased (if deceased due to medical condition, specify)

_____

**Other Paternal Relatives-**

**Other Maternal Relatives-**