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)

Highest education level completed: Less than high school High school/GED

Some college Assoc. Degree BA/BS degree Masters degree

Exercise: Yes No - Aerobics - Resistance How often _____

Tobacco Use: Yes No - cigarettes - cigar - pipe - dip/ snuff -Vaping

Amount per day _____ Interested in stopping? Yes No

Alcohol Use: Yes No Drinks per week _____

Non prescription Drug use: Yes No **Marijuana :** Yes No

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

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

with Male with Female

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-