

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 you have or had in past, or write in any not mentioned)

Heart/ Blood Vessels:

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

Lung/ Respiratory:

- Asthma
- Pulmonary Fibrosis
- COPD/ Emphysema
- Pneumonia
- Pulmonary Hypertension
- Bronchitis
- Tuberculosis

Neurological (nerves/ brain)

- Seizure Disorder
- Headaches– Migraine/ Sinus/ Tension/ Other
- Peripheral Neuropathy

Ear/ Nose/ Throat:

- Sinusitis
- Nasal Allergies
- Ear Infections
- Chronic Nasal Congestion
- Nasal Polyps
- Hearing Loss

Eye:

- Macular Degeneration
- Glaucoma
- Iritis
- Poor Vision

Stomach/ Liver/ Intestines/ Colon:

- Colitis
- Ulcers (stomach/ duodenal)
- Celiac Disease
- Diverticulosis
- Ulcerative Colitis
- Reflux/ GERD/ Barrett’s
- Constipation
- Diverticulitis
- Crohns Disease
- Hemorrhoids
- Irritable Bowel Syndrome
- Milk (lactose) Intolerance

Kidney/ Urinary:

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

Male Genital:

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

Gynecologic (female reproductive):

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

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

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