**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Male **[ ]** Female **[ ]** Preferred Language: English Spanish Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address/City\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies to medications** (and what happens if when taken) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all Medications/Vitamins: Please include strength and frequency of dosages:**

**Medications taken within the past six months:**

Plavix, or Coumadin…Y/N Aspirin…(**NOT** Tylenol or Ibuprofen)…Y/N Sleeping pills…Y/N

**Please circle all that apply:**

**Past Medical History**: Hypertension (High blood pressure), Diabetes Mellitus, Insulin Dependent Diabetes Mellitus, Stroke, Heart Attack, Congestive Heart Failure, Gout, Hyperthyroid, Hypothyroid, Asthma, COPD, Hepatitis, Pancreatitis, GERD, Lupus, Rheumatoid Arthritis, Osteoarthritis, Cancer, High Cholesterol, Kidney Disease, Dialysis, Depression or Mania, Gastritis, Seizures, Migraines

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: Do any family members have the following?** Please place an X in the appropriate box if any of these apply.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | High Blood Pressure | Heart Attack | Stroke | Diabetes | Cancer(please list type) | High Cholesterol | Tuberculosis | Hemophilia |
| **Mother** |  |  |  |  |  |  |  |  |
| **Father** |  |  |  |  |  |  |  |  |
| **Sister** |  |  |  |  |  |  |  |  |
| **Brother** |  |  |  |  |  |  |  |  |
|  | None of theabove | None of the above | None of the above | None of the above | None of the above | None of the  above | None of  the above | None of  the above |

**How many Brothers do you have \_\_\_ How many sisters do you have?\_\_\_ Children: How Many Sons:\_\_\_ Daughters\_\_\_**

**How many Sons do you have\_\_\_ How many daughters do you have:\_\_\_\_**

**Educational Level:** (**circle number of years of each**)

**High School:**1,2,3,4, diploma **College:** AA. BA, BS  **Postgraduate:**  M.A., M.S., MD, JD, MBA, Ph.D.

Are you employed? Full time Part time Not employed Disability Retired

What kind of work do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What is your job title at work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**: (Circle One) Single Married Separated Divorced Widowed.

Are you living with your husband or wife? **Y/N** Do you have (dependents) at home? **Y/N**

**Gynecological**: (females only)

Age periods started?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do periods last?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been pregnant?\_\_\_\_\_\_\_\_\_

Number of Miscarriages?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last PAP Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last mammogram?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Have you ever smoked? **Y/N** If yes, how many packs per day? \_\_\_\_ If yes, what year did you start?\_\_\_\_\_\_\_ When Quit?\_\_\_\_\_\_\_

Do you drink alcohol? **Y/N** If yes, how much do you drink? 1-3 4-6 7-9 9-12 **per** day/week/month

Do you Vape: **Y/N** If yes, what oils do you use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ what year did you start?\_\_\_\_\_\_\_ When Quit?\_\_\_\_\_\_\_

**Have you ever used any of the following:** (Circle items previously used)

Marijuana, Cocaine, Methamphetamines, LSD, PCP, Ecstasy, Speed, Heroin, Mushrooms, THC,

Cannabinoids (vaped or edible)

**When was the last time you used?**\_\_\_\_\_\_\_\_\_\_

**Past Surgical History:** Gallbladder Removal, Appendix Removal, Thyroid Removal, Tonsillectomy, Hysterectomy, C-Section, CABG (open heart surgery), Hernia Repair, Angioplasty, Cancer Surgery, Hip replacement, Knee surgery

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year(s) of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle all that applies to how you are feeling **right now:**

**General**: Fevers, Fatigue, Sweats, Chills**,**

**Endocrine**: Excessive Thirst, Weight Loss, Weight Gain

**Heme**: Unusual easy Bruising, Unusual Unstoppable Bleeding

**Allergy/Immunology**: Sinus Problems, Hay Fever (Allergic Rhinitis)

**HENT**: Sore Throat, Earache, Runny Nose (Rhinorrhea), Bruxism (teeth grinding)

**Eyes**: Red Eyes, Eye Discharge (Crusting), Double Vision (Diploplia)

**Pulmonary**: SOB (Dypsnea), Dry Cough (No Phlegm), Productive Cough, Wheezing

**Heart**: Palpitations (Irregular Heart Beat), High Blood Pressure, Rapid Heart Rate (Heart Racing)

**GI**: Nausea, Vomiting, Diarrhea, Abdominal Pain or Cramps, Heartburn

**GU**: Burning or Painful Urination (Dysuria), Blood in Urine (Hematuria),

**GU**: (Female patients) Pelvic or Genital Pain, Abnormal Vaginal Pain, Menstrual Pain, Vaginal Discharge

**Musculoskeletal**: Joint Pain, Muscle Pain

**Neurology**: Headache, Seizures, Vertigo (Room Spinning)

**Psychiatry**: Anxiety, Depressed or Sad

**Skin**: Rashes

As part of our continuing compliance with the Patient Protection and Affordable Care Act of March 23, 2010 there is some information that we require from you in order to update the patient information in our records.

|  |  |  |  |
| --- | --- | --- | --- |
| **RACE** | **Ethnicity** |  **Preferred Language** | **Lifestylel Preference** |
|  American Indian or Alaskan Native |  Hispanic |  English | Gender Identitiy Male Female |
|  Asian |  Non-Hispanic |  Spanish |  Heterosexual |
|  Black |  Caucasian |  Hindi |  Homosexual |
|  Caucasian |  |  French |  Bisexual |
|  Other |  |  Italian |  Other |
|  Pacific Islander |  |  Japanese |  Decline to disclose |
|  Declined |  |  Other |  Transgender |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Signature Physician’s Signature Date