Autumn Medical Group

9200 Colima Rd. #207 :: Whittier, CA 90605 :: (562) 945-0252

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 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	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?_______________

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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