Patient Name:_____

Chief Complaint today:_____

Height: Weight:

Past Medical History **ILLNESS/INJURY: Please check if you have ever had:**

Yes	No		Yes	No	
		AIDS			Gallstones
		Anemia			Hepatitis
		Anxiety Disorder			High Cholesterol
		Arthritis			High Blood Pressure (Hypertension)
		Asthma			Trouble Sleeping (Insomnia)
		Back Pain			Kidney Disease
		Bipolar			Liver Disease
		Cardiac Arrest			Migraines
		Chest Pain			Heart Attack (Myocardial Infarction)
		COPD			Nausea
		Chronic Pain			Osteoporosis
		Deep Vein Thrombosis			Peptic Ulcer
		Depression			Psoriasis
		Diabetes Type I			PTSD
		Diabetes Type II			Sleep Apnea
		Diverticulosis			Stroke
		Dizziness			Thyroid Disorder
		Eczema			Vomiting
		Esophageal Reflux			Well Child Exam
		Fibromyalgia			

OPERATIONS: List names and dates of all operations you have had **☐ None**

Year	Name of Operation	Type of Anesthetic, if Known Complications

Have you ever had a blood transfusion? ☐ Yes ☐ No Date: _____

List any hospital admissions or medical conditions not list above:

_____

MEDICATIONS: Please list all drugs you take and their dosages. ☐ None

Drug Dosage	Drug Dosage

ALLERGIES TO MEDICATIONS: Please list type and reaction **☐ None**

Name of Drug Reaction	Name of Drug Reaction

Patient Name:_____

Diagnostic Testing: Please list type and Year it was last done	**☐ None**
Name Procedure/Labs Year	Where was this performed? Ordering Provider
Last blood draw/Labs:	
Colonoscopy:	
Mammogram:	

FAMILY HISTORY: Has any member of your family ever had the following?

Which family member(s)?	Mother/Age	Father/Age	B=Brother/Age S=Sister/Age
Breast Mastectomy			
High Blood Pressure (Hypertension)			
Heart Disease			
Stroke			
Diabetes (Enter Type 1 or Type 2)			
Cancer			
Bleeding Disorders			
Mental Disease (anxiety, depression, etc)			
Drug or alcohol addiction (Enter “D” or “A”)			
Other:			

FEMALES ONLY: Date of last menstrual period? _____

Status of Social History: MUST COMPLETE

Tobacco? ☐ Current Some days ☐ Current Everyday ☐ Former ☐ Never Yrs Quit _____
Alcohol? ☐ Current Some days ☐ Current Everyday ☐ Former ☐ Never Yrs Quit _____
Marijuana? ☐ Current Some days ☐ Current Everyday ☐ Former ☐ Never Yrs Quit _____
Other? ☐ Current Some days ☐ Current Everyday ☐ Former ☐ Never Yrs Quit _____
Type: _____

MEDICARE – I request that payment of authorize Medicare benefits be made either to me or on my behalf to the above physicians for any services furnished by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named physicians any information regarding my Medicare claims under title XXVIII of the Social Security Act.

COMMERCIAL INSURANCE – I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim who performs the service. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

The above information is true and correct.
Patient Signature (parent if patient is a minor) : _____

In the event of an emergency do you have an Advance Directive, POLST, or Health Proxy?
(If yes, Please make sure we have one on file)
Are you interested in getting information on one?