

Referred by: __ Family __ Friend __ Internet __ TV __ Radio __ Mail __ Social Media

TODAY'S DATE: _____

Patient Information Form (Please Print)

	Primary Care Physician:		Have you been a patient of Primary Care Plus or Stanocola in the past? ☐ Yes ☐ No	
<u>PATIENT</u> ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	Last First MI		Date of Birth Age	
	Address		City State Zip	
	Social Security #: _____ Sex: ☐ Male ☐ Female		Are you a student? ☐ Yes ☐ No	
	Street Address (if different from mailing)		City State Zip	
	Phone (Home)		Name of Employer Employer's Phone #	
	Phone (Mobile)		Employer's Address	
	Preferred Method of Contact? ☐ Home Phone ☐ Mobile Phone May we send appointment and treatment reminders via text and voicemail? ☐ Yes ☐ No			
	Email:			
	Spouse's Name		Date of Birth	
<u>ADDITIONAL INFORMATION</u>	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐ Black ☐ White ☐ Hispanic ☐ Other ☐ Decline to Answer			
	Ethnicity: ☐ Hispanic ☐ Non-Hispanic		What Language do you prefer? ☐ English ☐ Spanish	
	Name of your Pharmacy		Address	
	City State Zip		Phone #	
<u>RESPONSIBLE PARTY</u> ☐ Self ☐ Spouse ☐ Guardian ☐ Other	Last First MI		Phone Number:	
	Address			
	City		State Zip	
<u>IN CASE OF EMERGENCY NOTIFY</u>	Name		Relation	
	Address		Phone #	
<u>INSURANCE INFORMATION</u>	<u>Primary Insurance</u>		Address	
	Policy Contract #	Group #	City	State Zip
	Name of Policy Holder		Date of Birth	
	<u>Secondary Insurance</u>		Address	
	Policy Contract #	Group #	City	State Zip
	Name of Policy Holder		Date of Birth	

PATIENT INFORMATION FORM

Patient's Name: _____ Guardian's Name (if under 18): _____

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

<u>Medication or Other (Environmental)</u>	<u>Reaction</u>

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

<u>Condition</u>	<u>Mother</u>	<u>Father</u>	<u>Maternal Grandparents</u>	<u>Paternal Grandparents</u>	<u>Brother</u>	<u>Brother</u>	<u>Sister</u>	<u>Sister</u>	<u>Additional Sibling(s)</u>
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

<u>Relationship</u>	<u>Cause of death</u>	<u>Age at death</u>	<u>Relationship</u>	<u>Cause of death</u>	<u>Age at death</u>

YOUR HEALTH HISTORY

(Check if you have had any of the following)

Abnormal Heart Rhythm	Chronic Pain	Heartburn/GERD	Obesity
Allergies (any)	Chronic Kidney Disease	Heart Murmur	Osteoporosis
Anemia	Depression	Hepatitis	Peripheral Vascular Disease
Anxiety/Stress	Diabetes	High Blood Pressure	Seizures/Epilepsy
Asthma	Emphysema/COPD	High Cholesterol	Sleep Apnea
Arthritis	Gallbladder Disease	HIV/AIDS	Stomach Ulcers
Atrial Fibrillation	Gout	Irritable Bowel Syndrome	Stroke
Colitis or Crohn's Disease	Headaches/Migraines	Kidney Failure	Thyroid Disease
Cancer	Heart Attack/Failure	Kidney Stones	

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

<u>Test</u>	<u>Date</u>	<u>Results</u>	<u>Physician</u>	<u>Vaccine Type</u>	<u>Date</u>
Colonoscopy				Tetanus (Td)	
Cholesterol Screening				Pneumonia	
Cardiac Stress Test				Hepatitis B	
Bone Density				Influenza (Flu)	
Mammogram				Shingles	
Breast Exam				Other	

OB/GYN HISTORY

Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/miscarriages	
Number of living children	

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO** If yes, please describe

PAST SURGICAL HISTORY

<u>Date</u>	<u>Surgery</u>	<u>Date</u>	<u>Surgery</u>

Please List Any Additional Medical Information:

HEALTH HABITS HISTORYDo you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ____ How many packs per day? ____Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

LIST ALL PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Ordering Provider</u>

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? YES NO (circle one)If yes, please supply the office with a copy for your chart. If no, would you like one? YES NO (circle one)