Name	
Date of Birth	
Gender	______Female ______Male ______Other
Preferred Language	
Email Address	
Allergies (List all medication / health products with which you have had a bad reaction and what type of reaction occurred)	**Medications** 1. ______ 2. ______ 3. ______ **Foods** 1. ______ 2. ______ 3. ______ **Other Allergy (Pets, Pollen, etc.)** 1. ______ 2. ______

Please indicate your race by checking the appropriate box	✔
White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.	
Black or African American – A person having origins in any of the Black racial groups of Africa.	
American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.	
Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
All Other Races	
Declined to Specify	
Please indicate your ethnicity by checking the appropriate box	
Hispanic/Latino	
Not Hispanic/Latino	

NAME: ____ DOB: ___________________________________

Do you have any special language and/or cultural needs?___________Yes________No
If yes, what are they?

What is your legal marital status? Mark (X) in the appropriate box(es)			
Annulled		Divorced	
Domestic Partner		Legally Separated	
Married		Single (Never Married)	
Widow			

Who do you live with? (Mark all that apply)					
Alone		With spouse/partner		Family member/friend	
Paid Caregiver		Independent Living Facility		Senior Housing or apartment	
Congregate or Assisted Living		Nursing Home Facility			

Is there anyone else involved with your health care decisions?					
No, just me		Family		Power of Attorney	
Public Fiduciary		Guardian		Spouse/Partner Other	
If yes, Name: Phone Number:					

Do you have a caregiver who provides you with any assistance?______Yes_______No
What is their name?____
Phone Number: ____
If yes, what type of assistance?

Tell us about your home environment		
	Yes	No
Do you have pets?		
Do you have a smoke detector?		
Do you have a carbon dioxide detector?		
Does anyone in your household smoke?		
Do you have a gun in your home?		

What is the highest level of education you completed?			
	✔		✔
Elementary School		College 1 Year	
7th Grade		College 2 Years	
8th Grade		Associates Degree	
9th Grade		Bachelor's Degree	
10th Grade		Vocational Degree	
11th Grade		Master's Degree	
12th Grade		Doctorate	

Currently attending School?_____Yes_____No_______Fulltime_____Part-time
If yes, what are you working towards?

NAME: ____ DOB: ___________________________________

What is your current work status?			
Disabled		Retired	
Unemployed		Work with Restrictions	
Employed Full time		Employed Part time	
If you are currently employed, what is your occupation?			

What is your current diet? Mark an (X) beside the appropriate box			
Healthy, Well Balanced		Diabetic	
Greater than 70 grams of Fat		Gluten-Free	
Greater than 90 grams of Sugar		High Fiber	
Greater than 50 grams of Protein		Lactose-Free	
Greater than 2300 milligrams of Sodium		Renal	
1200 Cal Ada		Vegan	
1200 Cal Ada		Vegetarian	
1800 Cal Ada		Mechanical soft	
Cardiac		Other	
Low Cholesterol		Other	

What is you spiritual Orientation?			
Adventist		Muslim	
Baptist		Non-Roman Catholic	
Catholic		Protestant	
Christian		Spiritualism	
Hinduism		Voodoo	
Islam		Zen Buddhism	
Independent		Agnostic	
Jehovah's Witness		Atheist	
Jewish		Other	

How would you describe your sleep pattern?			
Normal sleep activity		Continuous disturbances	
Daytime drowsiness		Difficulty falling asleep	
Early morning awakening		Snoring that disturbs sleep	
On average how many hours do you sleep per night? __________			

Which is your dominant hand?			
Left		Right	
Both (Ambidextrous)			

NAME: ____ **DOB:** ___________________________________

How would you rate yourself over the past month?				
My hearing is	Good	Fair	Poor	Good with Hearing Aid
My vision is	Good	Fair	Poor	Good with glasses or contact lenses
I can walk	Without assistance	Fairly well with a Cane	Okay with a walker	I cannot walk

Have you completed a Living Will, Advance Directives, or other Health Care Wishes document? (circle the correct answer)			
Yes	**No**	**I Don't Know**	**I would like to talk to the Doctor about it**
****If yes, please bring a copy with you to your next appointment with our office.			
Do you have a healthcare proxy?______Yes_______No What is their name? ____ Phone Number: ____			

Please review the following list. If you have any of these conditions check Yes or No and the approximate year of diagnosis. If you have other conditions not listed, please write them down in the space provided.							
Condition / Disease	Yes	No	Year	**Condition / Disease**	Yes	No	Year
Alcoholism / Cirrhosis				Cataracts			
Anemia				Diabetes (high blood sugar)			
Arthritis				Gallbladder disease / stones			
Asthma / Emphysema				Glaucoma			
Bleeding / Blood Disorders / Clots				Crohn's disease / colitis			
Bone or spine				Heart disease			
Cancer (past)				Heart attack (MI)			
Leukemia				Hepatitis / Jaundice / Liver			
Lymphoma				High blood pressure			
HIV positive / AIDS				Thyroid disease			
Lung disease				Tuberculosis			
Prostate disease				Ulcers / stomach pain			
Seizures / epilepsy				Other:			
Stroke(s)				Other:			
Other:				Other:			
Other:				Other:			

MENTAL HEALTH/SUBSTANCE ABUSE HISTORY

1. Do you have a history of substance abuse?**______Yes_______No** (If yes check the boxes below)
2. Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) history of substance abuse?**______Yes_______No**
3. Do you have a history of mental health condition?**______Yes_______No** (If yes check the boxes below)
4. Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of mental health condition?**______Yes_______No**

Please review the following list. If you have any of these conditions check Yes or No If any other condition(s) or substance(s) not listed, please write them down in the space provided.

NAME: ______________________________ DOB: ______________________

MENTAL HEALTH			SUBSTANCE ABUSE/DEPENDENCE		
Condition / Disease	Yes	No	**Substance/Drug**	Yes	No
Alcohol/Substance Abuse			Caffeine (pills or beverages)		
Alcohol/Substance Dependence			Cocaine		
Anxiety Disorders			Crystal Meth-Amphetamine		
Adult Attention Deficit/Hyperactivity Disorder (ADHD/ADD)			Heroin		
Bipolar Disorder			Inhalants		
Depression			LSD or Hallucinogens		
Eating Disorders			Marijuana		
Generalized Anxiety Disorder			Methadone		
Obsessive-Compulsive Disorder			Pain Killers		
Panic Disorder			PCP		
Postpartum Depression			Stimulants (pills)		
Posttraumatic Stress Disorder (PTSD)			Tranquilizers/Sleeping Pills		
Schizophrenia			Ecstasy		
Other:			Other:		
Other:			Other:		
Other:			Other:		

Please list your Doctor(s)		
Type of Doctor	**Name (First and Last if known)**	**Telephone Number**
Heart (Cardiologist)		
Kidney (Nephrologist)		
Cancer (Oncologist)		
Eye (Ophthalmology)		
Psychiatrist		
Mental Health Counselor		
Pain Management		
GYN (Obstetrics & Gynecology)		
Lungs (Pulmonologist)		
Foot (Podiatry)		
Diabetes/Thyroid (Endocrinologist)		
Urologist		
Gastroenterologist		
Orthopedic		

In the past year, have you had any of the following screening tests or vaccines?	Yes	Date	No	Help me Schedule
Colorectal cancer screening				
Flu vaccine				
Pneumonia vaccine				
Shingles vaccine				
Eye exam				
Dental exam				
Cervical Cancer screening (PAP) (Female)				
Bone Mineral Density Screening				
Breast Cancer Screening (Female)				

NAME: ____ DOB: ___________________________________

Review of Symptoms
Review the following and Check **C for current problem** or **P for past problem** in space provided. Leave the spaces blank if you have never had any of the following.

Problem	C	P	Problem	C	P
Pain - Where?			Muscle pain or weakness		
Fatigue / weakness			Numbness or tingling		
Fevers / chills / night sweats			Difficulty walking		
Lump(s) or swelling			Decreased appetite		
Rashes / Moles			Abdominal pain / Swelling		
Bruising easily			Black or bloody stools		
Bleeding or Blood clotting			Bloating		
Sleeping disturbance / insomnia / too much sleep			Constipation		
Weight loss or gain (how much?)			Diarrhea		
Changes in Breast / Breast Lumps			Increased gas		
Headaches			Nausea and/or vomiting		
Vision changes			Needing to urinate frequently		
Seizures / epilepsy			Bladder pain or pain with urination		
Memory loss			Bleeding with urination		
Dental problems / Hoarseness			Lump(s) in testicles		
Mouth sores			Loss of sexual potency		
Sinus trouble			Hot flashes		
Chest pain / Pressure			Vaginal discharge / Odor / Bleeding		
Ankle swelling			Pain with intercourse		
Rapid heartbeat			Feel Depressed		
Cough			Loss of interest in usual activities		
Cough up blood			Recent infections or allergies		
Difficulty swallowing			Other:		
Difficulty breathing					

Medications (List all medication names including non-prescription medications, vitamins, herbs, or supplements.) Please include the dosage, and how many you take daily (example: Lasix 20 mg 1 tablet daily)

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

NAME: ______________________________ DOB: ______________________

FAMILY HISTORY

PLEASE LIST BELOW ANY PERTINENT MEDICAL ILLNESSES IN YOUR FAMILY

Condition	Y	N	Family Members (Circle all that Apply)	Age of Onset
Abnormal PAP			Parent; Grandparent; Sibling; Other	
Acne			Parent; Grandparent; Sibling; Other	
ADHD			Parent; Grandparent; Sibling; Other	
Anemia			Parent; Grandparent; Sibling; Other	
Anxiety			Parent; Grandparent; Sibling; Other	
Arthritis			Parent; Grandparent; Sibling; Other	
Alzheimer’s			Parent; Grandparent; Sibling; Other	
Bleeding Disorder			Parent; Grandparent; Sibling; Other	
Blood Clots			Parent; Grandparent; Sibling; Other	
Bronchitis			Parent; Grandparent; Sibling; Other	
Cancer			Parent; Grandparent; Sibling; Other	
Cataracts			Parent; Grandparent; Sibling; Other	
Chicken Pox			Parent; Grandparent; Sibling; Other	
COPD/Emphysema			Parent; Grandparent; Sibling; Other	
Depression			Parent; Grandparent; Sibling; Other	
Diabetes			Parent; Grandparent; Sibling; Other	
Diptheria			Parent; Grandparent; Sibling; Other	
Eczema			Parent; Grandparent; Sibling; Other	
Fracture			Parent; Grandparent; Sibling; Other	
Glacoma			Parent; Grandparent; Sibling; Other	
Heartburn (Reflux)			Parent; Grandparent; Sibling; Other	
Heart Attack			Parent; Grandparent; Sibling; Other	
Heart Failure			Parent; Grandparent; Sibling; Other	
Heart Murmur			Parent; Grandparent; Sibling; Other	
Hemorrhoids			Parent; Grandparent; Sibling; Other	
Hernia			Parent; Grandparent; Sibling; Other	

Condition	Y	N	Family Members (Circle all that Apply)	Age of Onset
High Blood Pressure			Parent; Grandparent; Sibling; Other	
High Cholesterol			Parent; Grandparent; Sibling; Other	
HIV/AIDS			Parent; Grandparent; Sibling; Other	
Intestinal Disorder			Parent; Grandparent; Sibling; Other	
Kidney Disease			Parent; Grandparent; Sibling; Other	
Liver Diease			Parent; Grandparent; Sibling; Other	
Measles			Parent; Grandparent; Sibling; Other	
Meningitis			Parent; Grandparent; Sibling; Other	
Mental Illness			Parent; Grandparent; Sibling; Other	
Migraines			Parent; Grandparent; Sibling; Other	
Mononucleosis			Parent; Grandparent; Sibling; Other	
Motor Vehicle Accident			Parent; Grandparent; Sibling; Other	
Multiple Sclerosis			Parent; Grandparent; Sibling; Other	
Mumps			Parent; Grandparent; Sibling; Other	
Parkinson’s			Parent; Grandparent; Sibling; Other	
Pneumonia			Parent; Grandparent; Sibling; Other	
Seizure Disorder			Parent; Grandparent; Sibling; Other	
Sexually Transmitted Disease			Parent; Grandparent; Sibling; Other	
Shingles			Parent; Grandparent; Sibling; Other	
Stroke			Parent; Grandparent; Sibling; Other	
Thyroid Disease			Parent; Grandparent; Sibling; Other	
Tuberculosis			Parent; Grandparent; Sibling; Other	
List Others Below:			Parent; Grandparent; Sibling; Other	
			Parent; Grandparent; Sibling; Other	
			Parent; Grandparent; Sibling; Other	
			Parent; Grandparent; Sibling; Other	