Qvita
HEALTH & WELLNESS
PRIMARY CARE AND COSMETIC SERVICES

Patient Demographics

LAST NAME		FIRST NAME	EMAIL
MIDDLE INITIAL	GENDER M or F	AGE and DATE OF BIRTH	
ADDRESS		CITY	STATE AND ZIP
HOME PHONE		CELL PHONE	SOCIAL SECURITY NUMBER

INSURANCE INFORMATION

RESPONSIBLE PARTY OR INSURANCE POLICY HOLDER→

LAST NAME	FIRST NAME	MI	MALE FEMALE
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	DOB	

MEDICAL INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	NAME OF POLICY HOLDER	
SOCIAL SECURITY NUMBER	ID NUMBER	GROUP NUMBER
NAME OF SECONDARY INSURANCE COMPANY	NAME OF POLICY HOLDER	
SOCIAL SECURITY NUMBER	ID NUMBER	GROUP NUMBER
NAME OF PRIMARY CARY PHYSICIAN	PHONE NUMBER	

MEANINGFUL USE REQUIRED BY LAW, PLEASE CIRCLE		
Race: American Indian or Alaskan Native, Asian, Native Hawaiian, or other Pacific Islander, Black or African American, White, Hispanic, other race, other Pacific Islander, unreported/refuse to report	**Ethnicity:** Hispanic, non-Hispanic, Refuse to report	**Language:** English, Spanish, Other If other please list here: _____

By signing below, I hereby certify that the above information is true and correct to the best of my knowledge and belief.

X_____ DATE: _____

Who may we thank for referring you to our office? _____

Emergency contact name: _____ Relationship to patient: _____

Emergency contact number: _____

What are you being seen for today? _____

MEDICAL HISTORY

Current Medications with Dosage (include prescribed and over the counter, vitamins and supplements):

Medication name	Dose	How often you take it

Pharmacy name: _____ Pharmacy number: _____

Are you currently being treated for any of the following? (Please circle all that apply)

Diabetes	Thyroid Disease	High Blood Pressure	High Cholesterol	Heart Disease
Asthma	Cancer	Osteoporosis	Kidney Disease	Epilepsy
Stroke	Arthritis	Anemia	Bleeds Easily	Tuberculosis
Headaches	Hepatitis	Depression/ Anxiety	HIV	Allergies

Other: _____

Are you currently seeing any other physicians? No Yes If yes, please list:

_____

_____

Allergies (Please list your allergies below with the type of reaction):

_____

_____

Surgeries/ Accidents/ Hospitalizations (Please list and include dates):

_____

_____

_____

FAMILY HISTORY

Family Member	Age	Alive/Deceased	If deceased, cause of death
Father			
Mother			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Siblings: Brothers→			
Siblings: Sisters→			

FAMILY HISTORY CONTINUED

Please check if your family member **has** or **had** the listed chronic condition:

Condition:	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENTS	OTHER
Hardening of arteries						
Arthritis						
Asthma						
Heart Disease						
Cancer						
Cataract						
Color Blind						
Depression						
Diabetes Mellitus						
Eczema						
Epilepsy						
Glaucoma						
High Blood Pressure						
High Cholesterol						
Central loss of Vision						
Mental Illness						
Migraine headaches						
Osteoporosis						
Kidney Disease						
Retinal Detachment						
Stroke						
Thyroid Disease						

If other, please specify: _____

SOCIAL HISTORY

Employer and Occupation: _____

Occupational Exposures:

☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ noise

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have a Living Will? ☐ No ☐ Yes

Do you have an Advanced Directive? ☐ No ☐ Yes

Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Drinks/week/day: _____ Type: _____

Tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Packs/day: _____ Previously, but quit when? _____

Caffeine: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Amount Daily: _____ Type: _____

Use of Drugs: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Previously, but quit when? _____ Type: _____

Do you travel outside of the USA? ☐ No ☐ Yes

If yes, where? _____

Are you sexually active? ☐ No ☐ Yes

Smoke Detector in your home? ☐ No ☐ Yes

Do you have any pets? ☐ No ☐ Yes

If yes, list type and number: _____

Religion (optional): _____

Do you exercise? ☐ No ☐ Yes

If yes, how often and what type: _____

PREVOUS SCREENINGS (men and women)

Date of Last colonoscopy: _____

Date of last bone density: _____

Date of last rectal exam: _____

Date of last mammogram: _____ N/A

Date of last complete labs: _____

Date of last pelvic exam and pap: _____ N/A

Date of last chest x-ray: _____

Date of last PSA: _____ N/A

Date of diabetic foot exam: _____ N/A

Date of last glaucoma screening: _____ N/A

Abdominal Ultrasound or CT: _____

IMMUNIZATIONS

Hepatitis B _____ Date: _____

Chicken Pox _____ Date: _____

Tetanus _____ Date: _____

Pneumococcal _____ Date: _____

Influenza _____ Date: _____

Gardisil _____ Date: _____

Other _____ Date: _____