PATIENT INFORMATION FORM

Please Print

Name: ______________________ Date of Birth: ______________ Sex: __ M __ F

Mailing Address: ______________________ City/State/ Zip: ______________

SS# ___-__-____ Marital Status: __________ Email address: ______________

Home Phone # (___) ___-____ Cell Phone# (___) ___-____ Work Phone# (___) ___-____

Are you a student: Yes _____ No _____ Full Time: _______ Part Time: _____

Employer: ______________________ Full Time: _____ Part Time: _____ Not Employed: _____

Emergency Contact (Not living with you):

Name: ______________ Relationship: ______________ Phone#: (___) ___-____

Name: ______________ Relationship: ______________ Phone#: (___) ___-____

Appointment Reminder Call Contact # (please circle one) ***Home*** ***Cell***

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino ☐ Other ☐ Unreported/ Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report

Preferred Language: ☐ English ☐ Indian ☐ Spanish ☐ Russian ☐ Other __________

RESPONSIBLE PARTY INFORMATION

Name: ______________________ Date of Birth: ______________ SS# ___-__-____

Address: ______________________ City/State/Zip: ______________

Home Phone # (___) ___-____ Cell Phone# (___) ___-____

Relationship to patient: ______________

Primary Insurance Name ______________________ Name of Policy Holder ______________

Primary Policy Holder Date of Birth __________ SS# ___-__-____ Relationship to Patient ______________

Secondary Insurance Name ______________________ Name of Policy Holder ______________

Secondary Policy Holder Date of Birth __________ SS# ___-__-____ Relationship to Patient ______________

How did you hear about us? ☐ Radio ☐ Newspaper ☐ Website ☐ Referral ☐ Other __________

CONSENT TO OBTAIN MEDICATION HISTORY

Patient ID:____________ **Date:**______________

As a user of an electronic medical record, Gagon Family Practice would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors may have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is very important to help us treat you and avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and to give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include drugs purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

______________________________________ ______________________

Print Patient Name Patients Date of Birth

______________________________________ ______________________

Signature of Patient or Guardian Relationship to Patient

5/15/2014

Name ______________________ Date ______________

Health History Form for NEW Patients

Welcome to our practice! Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions.

Medications: Please, list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, herbs, etc.

Medication	Dose (e.g. mg/pill)	How many times per day?

Local Pharmacy: ______________________ **Mail in Pharmacy:** ______________________

Personal Medical History: Do you have now (current) or have you had (past) any of the following conditions?

Condition	Current	Past	Comments
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety/ Depression			
Arthritis			(Rheumatoid), (Osteoarthritis), (Gout)
Asthma			
Bladder / Kidney Problems / Disease			
Blood Clots			
Blood Transfusion			
Breast Lump (Benign)			
Cancer (please, specify type)			
Cataracts / Glaucoma			
Coronary Artery Disease / MI			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema / Lung			
Fracture (broken bones)			Where?
Gallbladder disease			
Gastroesophageal Reflux (heartburn/GERD) / Ulcers			
Gynecological Conditions			(Fibroids) or (Endometriosis)
Gynecological Conditions (other)			
High Blood Pressure			
Crohn's Disease / ulcerative colitis			
Congestive Heart Failure			
High Cholesterol			

Liver Disease			
Migraine Headaches			
Prostate			(Enlargement) or (Nodules)
Seizure / Epilepsy			
Skin condition			
Sleep Apnea			
Thyroid (nodule)			
Thyroid High (hyperthyroidism)			
Thyroid Low (hypothyroidism)			
Other (list)			
Other (list)			

Allergies or intolerance to medications (include type of reaction

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Women's Health

Total number of pregnancies: _____ Number of births:________

Date (month /day if known) of last menstrual period: _________

Age at beginning of periods (menstruation): _________

Age at end of periods (menopause): __________

Mammogram	Date___________	Abnormal?	☐No	☐Yes
Pap Smear	Date___________	Abnormal?	☐No	☐Yes
Bone Density	Date___________	Abnormal?	☐No	☐Yes

Surgical History – Please check off any procedure or surgeries. List any abnormal finding or complications. ☐**NONE**

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (appendix removal)			
Back Surgery			
Biopsy (location)			
Breast Surgery			
Colonoscopy / Sigmoidoscopy			
Coronary Bypass / Stent			
EGD (Stomach Endoscopy)			
Cataract / Eye Surgery			
Gallbladder Removal			
Heart Surgery (other than coronary bypass)			
Hip Surgery			
Hysterectomy (total) or (partial –ovaries left) / Ovary Removal			
Knee Surgery			Circle: Right Left Both
LEEP Cervix Surgery)			
Neck Surgery			
Ovary Ligation ("Tubal")			
Vasectomy			
Sinus Surgery			
Other (list)			

Family History – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Ovarian/ Uterine										
Cancer Prostate										
Cancer Skin										
Cancer Other										
Coronary Artery Disease, (e.g. heart attack, angina)										
Depression/Suicide/Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Heart Disease (CHF) / Other										
Hepatitis B or C										
High Blood Pressure										
High Cholesterol										
Hypothyroidism										
Kidney Disease/ Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis / Osteopenia										
Other (please, list)										

Other Health Issues:

Tobacco Use

Smoke cigarettes: ☐Never ☐No ☐Yes

Quit date: ___________ How many years did you smoke? _____

Approximately how many packs a day did you smoke? ________

Current Smoker: Packs/day: _______ # of years: ________

Other Tobacco Use: ☐ Pipe ☐ Cigar ☐Snuff ☐Chew

Street Drugs (other drug use) ☐ Yes ☐ No

Have you had or currently have (mark answer)?

☐Hepatitis (B, or C) ☐HIV

☐AIDS ☐STD's

Immunizations

Flu Vaccination (current season) ☐No ☐Yes

Pneumonia Vaccination ☐No ☐Yes, approximate date __________

TB Test ☐No ☐Yes, approximate date___________