GAGON FAMILY PRACTICE

NEW PATIENT INFORMATION FORM

Please Print

Name: _____ Birth Date: _____ Sex: __ M __ F

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: _____

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: _____

Please list names of all family household members that are seen in our office:

Name: _____ DOB: _____ Name: _____ DOB_____

Name: _____ DOB: _____ Name: _____ DOB: _____

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

PLEASE PROVIDE THE RECEPTIONIST YOUR INSURANCE CARD(S)

We will need to make a copy at each appointment to insure correct billing. Thank you!

GAGON
FAMILY PRACTICE

_____

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_____