

WELCOME TO *ASSOCIATES IN PRIMARY CARE, INC.*

Welcome to our practice. How did you hear about us? _____

Name _____ Today's date _____
Gender ___F___M Marital Status: Married___ Single___ Divorced___
Race/Ethnicity _____ Widowed___ Living with partner ___
Address _____ Date of birth _____
_____ Social Security # _____
Phone(home) _____ (work) _____ (cell) _____
Primary Language Spoken _____ Primary Language Written _____
In case of emergency, please notify _____ Phone _____
Address _____
Relationship _____

EMPLOYMENT INFORMATION

Employer name _____ Occupation _____
Address _____
Phone _____

MEDICAL INSURANCE INFORMATION

Primary Insurance _____ Policy # _____
Cardholder name _____ Date of birth _____
Social Security # _____ Copay _____
Employer for insurance coverage _____

Secondary Insurance _____ Policy # _____
Cardholder name _____ Date of birth _____
Social Security # _____ Copay _____
Employer for insurance coverage _____
Pharmacy name _____ Telephone _____

MEDICAL INFORMATION

Why are you seeing the doctor today? _____

Did you injure yourself? ___ If so, what was the date? _____ Place first treated _____

List any tests that have already been done _____

Do you have any known drug allergies? ___ Drug _____ Reaction _____

PARTY RESPONSIBLE FOR PAYMENT (IF NOT ABOVE OR IF PATIENT IS A MINOR)

Last name _____ First name _____ MI _____
Father/guardian's name _____ Mother/guardian's name _____
Date of birth _____ Social Security # _____ Gender ___M___F
Street Address _____ City _____ State _____ Zip _____
Occupation _____ Work phone _____ E-mail _____

MEDICATIONS CURRENTLY TAKING

Medication_____	Dose_____	Times per day_____
Medication_____	Dose_____	Times per day_____
Medication_____	Dose_____	Times per day_____
Medication_____	Dose_____	Times per day_____
Medication_____	Dose_____	Times per day_____

PAST MEDICAL HISTORY

(Please check *all* that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Hearing disorder | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headache | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Anesthesia problems | <input type="checkbox"/> Heart | <input type="checkbox"/> Stomach reflux |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart rhythm problem | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids/Diarrhea | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis/Liver | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis/Emphysema | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Cancer (type) | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> or Crohn's disease |
| _____ | <input type="checkbox"/> Kidney illness | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Eye disease | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Psoriasis/eczema | |
| <input type="checkbox"/> Hay Fever Allergy | <input type="checkbox"/> Recent weight loss | |
| <input type="checkbox"/> Emotional Problems | | |

SURGERIES/HOSPITALIZATIONS Indicate the year or age that you had any of the listed surgeries

- | | |
|--|--|
| <input type="checkbox"/> Appendectomy_____ | <input type="checkbox"/> Kidney/Bladder_____ |
| <input type="checkbox"/> Breast biopsy/mastectomy_____ | <input type="checkbox"/> Tonsillectomy_____ |
| <input type="checkbox"/> C-Section_____ | <input type="checkbox"/> Tubal Ligation_____ |
| <input type="checkbox"/> Cardiac Surgery_____ | <input type="checkbox"/> Tubes in Ears_____ |
| <input type="checkbox"/> Cataract Surgery_____ | <input type="checkbox"/> Vasectomy_____ |
| <input type="checkbox"/> Colon Rectal Surgery_____ | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> D & C_____ | |
| <input type="checkbox"/> Gallbladder Removal_____ | |
| <input type="checkbox"/> Hysterectomy_____ | |

WOMEN ONLY

Last menstrual period _____ Are you using birth control _____
Pregnancies: Total number _____ Live births _____ Miscarriages _____ Abortions _____
Year of last: PAP Test _____ Breast Exam _____ Mammogram _____
Results _____
Type of contraception? _____

MEDICAL HISORY (additional medical you want the doctor to know about)

FAMILY HISTORY **If living, age, health** **If deceased, age, health at death**
Father _____
Mother _____
Brothers, Sisters _____
Husband/Wife/Partner _____
Sons/Daughters _____

HAS ANY BLOOD RELATIVE EVER HAD:

Whom

Cancer; colon, breast, prostate Yes ___ No ___ _____
Diabetes Yes ___ No ___ _____
Heart Trouble Yes ___ No ___ _____
High Blood Pressure Yes ___ No ___ _____
Stroke Yes ___ No ___ _____
Migraine Yes ___ No ___ _____
Suicide, mental disorder Yes ___ No ___ _____
Alcohol problem Yes ___ No ___ _____
Serious Osteoporosis Yes ___ No ___ _____

SOCIAL HISTORY

Do you smoke now ___Yes ___No Quit Date _____
How many packs per day? ___ # of years ___ Have you tried quitting? _____
Do you drink alcohol? ___Yes ___No
Have you ever had any problems related to drinking alcohol? _____
(i.e. DUI, missed school or work, family or medical problems)
How many cups of coffee do you drink a day? ___ Cans of cola? ___ Glasses of milk? ___
Do you use any kind or recreational drugs? ___Yes ___No (i.e. marijuana, cocaine, etc)
Do you drink beverages with caffeine? ___Yes ___No # per day _____
Have you traveled outside the United States in the past year? ___Yes ___No Date _____
Are you currently sexually active? ___Yes ___No
Have you ever had a sexually transmitted disease/venereal disease? ___Yes ___No
If yes which disease? _____
Do you wear seatbelt when you drive? ___ Yes ___ No
How many days do you exercise at least 1/2 hour? _____
Last year of school attended? _____

ADULT WELLNESS AND PREVENTIVE CARE (approximate date)

Chest X-Ray _____	Eye Exam _____	Sigmoid scope _____
Colonoscopy _____	Flu vaccine _____	TB Test _____
Cholesterol Test _____	Hepatitis vaccine _____	Tetanus shot _____
Dental Exam _____	Pneumonia shot _____	
EKG _____	Stool blood test _____	

REVIEW OF SYSTEMS

Are you having or have you ever had recurrent problems with (*check all that apply*)

- | | |
|---|---|
| <input type="checkbox"/> Anxiety/depression/Psy.
hospitalization | <input type="checkbox"/> Frequent nosebleeds |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Frequent voiding # per night _____ |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Hay fever/hives |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Calf cramps with walking | <input type="checkbox"/> Jaundice or liver problems |
| <input type="checkbox"/> Chest pain/angina/palpitations | <input type="checkbox"/> Leg swelling/gout |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of or double vision |
| <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> Diarrhea/constipation/rectal bleeding | <input type="checkbox"/> Nausea and vomiting |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ear Pain | _____ |
| <input type="checkbox"/> Fainting/blackouts | _____ |
| <input type="checkbox"/> Fever/chills | _____ |
| <input type="checkbox"/> Painful voiding | |
| <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Severe headaches | |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Skin lesions/rashes | |
| <input type="checkbox"/> Sore Throat | |
| <input type="checkbox"/> Stomach pain or ulcers | |
| <input type="checkbox"/> Swollen glands | |
| <input type="checkbox"/> Unexplained weight gain/loss | |
| <input type="checkbox"/> Wheezing | |

IF YOUR CURRENT PROBLEM IS THE RESULT OF A WORK INJURY OR LIABILITY, PLEASE COMPLETE THE FOLLOWING:

Circle all that apply: **Car accident** **Work Accident** **Slip/Fall** **Other** _____

Cause of injury _____

Did you report this? _____

Date you last worked _____

Date you returned to work _____

If applicable, your Attorney's name and address _____

Phone _____

I understand that the answers and explanations that I have provided on these pages are important for my safety during and after my treatment, and I therefore certify that this information is true and accurate to the best of my knowledge.

I also understand that all charges are due at the time of service and that if it becomes necessary to bill me for any outstanding charges that I agree to pay a \$15.00 billing fee.

Insurance authorization and assignments: I hereby authorize Associates in Primary Care Medicine, Inc. to furnish information to insurance carriers or other third party payers the information concerning my diagnoses and treatment necessary to process claims for payment. I acknowledge that Associates in Primary Care Medicine, Inc. bills my third party payer as a service to me and that I am financially responsible for all charges that are deemed not covered or not medically necessary. I am aware that separate services may be covered differently depending on my policy, which is my responsibility to understand. I hereby assign to the physician all payments for medical services rendered to my dependents or to myself. This assignment will remain in effect until I revoke it in writing. A copy of this signature is valid as the original.

I give permission for the physician to treat my dependent or me medically.

Signature _____ **Date** _____

Printed name _____