DR. BARBARA

PATIENT INFORMATION

Patient Name_____ Date_____

Address _____

City, State, Zip _____ Sex ☐ Male ☐ Female

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Communication Preference ☐ E-Mail ☐ Home Phone ☐ Mobile Phone

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth _____ Age _____

Social Security # _____ Occupation _____ Employer_____

INSURANCE INFORMATION

Primary Insurance Provider _____

Name of Subscriber _____ Subscriber DOB _____

Subscriber ID _____ Group ID _____

Subscriber Social Security # _____

Secondary Insurance Provider _____

Name of Subscriber _____ Subscriber DOB _____

Subscriber ID _____ Group ID _____

Subscriber Social Security # _____

REFERRAL INFORMATION

Referring Physician _____

Address _____ City, State, Zip _____

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

Name and Relationship of Emergency Contact _____

Address_____ City, State, Zip _____ Telephone _____

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to specify
RACE ☐ Black or African American ☐ White ☐ Other Race ☐ Declined

PATIENT HEALTH HISTORY

Patient Name _____ Date_____

Occupation _____ DOB _____ Age _____

Pharmacy Name and Address _____

Laboratory Name and Address _____

Medical History

Do you have or have you ever had any of the following conditions? Please check:

Autoimmune Disease:
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Thyroid Disease
- ☐ Lupus

Cardiovascular:
- ☐ Atrial Fibrillation
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ High Blood Pressure

Gastrointestinal:
- ☐ Colitis/Diverticulitis
- ☐ Gastroesophageal Reflux (GERD)
- ☐ Ulcers
- ☐ Crohns Disease

Genito-urinary:
- ☐ Gender re-assignment
- ☐ Kidney Stones
- ☐ Urinary Tract Infections (UTIs)
- ☐ Kidney Disease
- ☐ Hiatal Hernia
- ☐ Liver Disease

Other medical conditions you may have:

Hematologic/Metabolic:
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Bruising
- ☐ DVT/Pulmonary Embolism

Lungs:
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD
- ☐ Tuberculosis

Musculoskeletal/Neurological:
- ☐ Arthritis
- ☐ Headache/Migraine
- ☐ Seizures
- ☐ Osteopenia/Osteoporosis
- ☐ Parkinson's

Other:
- ☐ Dementia/Alzheimer's
- ☐ Glaucoma
- ☐ High Cholesterol
- ☐ HIV
- ☐ Parkinson's/ Neuropathy
- ☐ ON CPAP for Sleep Apnea
- ☐ Stroke

_____

_____

Review of Systems
Please check only those symptoms you have developed:

Constitutional:
- ☐ Anxiety
- ☐ ADHD
- ☐ Bipolar
- ☐ Chills
- ☐ Depression
- ☐ Fatigue
- ☐ Headaches
- ☐ Weight Gain How much _____
- ☐ Weight Loss How much _____

Gastrointestinal:
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Nausea
- ☐ Poor appetite
- ☐ Vomiting

Ear, Nose, Throat:
- ☐ Allergies, Seasonal
- ☐ Ear Pain/Drainage
- ☐ Difficulty swallowing
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Post Nasal Drip
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Snoring
- ☐ TMJ

Neurological:
- ☐ Balance Problems/Dizziness
- ☐ Fainting
- ☐ Fall asleep easily during the day
- ☐ Headaches
- ☐ Memory Problems
- ☐ Seizure
- ☐ Tingling
- ☐ Tremors
- ☐ Blurred Vision
- ☐ Double Vision

Respiratory:
- ☐ Oxygen Dependence
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Wheeze

Genito-urinary:
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control

Musculoskeletal:
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Teeth Grinding

Skin:
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Sores that won't heal
- ☐ Psoriasis

Women Only:
- ☐ Abnormal Pap Smear
- ☐ Breast Cancer
- ☐ Breast Lump
- ☐ Hot Flashes

Men Only:
- ☐ Breast Lump
- ☐ Prostate Cancer
- ☐ Lump in testicles

Previous Surgery

Have you had any major surgeries?

☐ No ☐ Yes (please list below)

Surgery	Date

Medications

Please list ALL medications you take, including the over the counter medications and vitamins. Include specific doses and when taken.

Medication	Dosage	Reason for Taking

Are you allergic to any medications

☐ No ☐ Yes (please list below)

Name	Reaction

Family History

Do you have a family history (immediate family only) of medical problems? ☐ No ☐ Yes

☐ Alzheimer's	☐ Diabetes	☐ High Blood Pressure
☐ Parkinson's	☐ Hearing Loss	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Other:_____

Social History

Do you drink alcohol ☐ No ☐ Yes If Yes, _____ drinks per week

Do you smoke cigarettes? ☐ No ☐ Yes If Yes, how much _____

If you have quit smoking, when did you quit and how long did you smoke _____

Do you do any illicit drugs? ☐ No ☐ Yes If Yes, what drug/how often_____

Do you drink caffeine? ☐ No ☐ Yes If Yes, _____ drinks per day

Have you been exposed to HIV? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes First date of last period_____

Have you had any of these screening tests?

☐ No ☐ Yes (please list below)

Procedure	**Date**	**Result (normal/abnormal)**
Colonoscopy		
Mammogram		
Dexa (bone density)		