Pt Name______________________________________**Date**____________________**Acct**____________

PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

Name____(M / F) D.O.B.____________________
Address____
City____State_______Zip Code_____________
Home Ph.____________________Work Ph.____________________Cell Ph.___________________
Social Sec. #_______-______-_______ Marital Status (M) (S) (D) (W)
Employer_____________________________________ Email___________________________________
Referred By______________________________ Primary Care Phys.__________________________

Primary Insurance____ HMO PPO POS EPO Other
ID#____Grp#________________________
Insurance Holder(SELF)(SPOUSE)(PARENT) If not self, specify name_____________________
Insured Person's Employer_____________________________________and DOB________________

Secondary Insurance_______________________________________ HMO PPO POS EPO Other
ID#____Grp#________________________
Insurance Holder(SELF)(SPOUSE)(PARENT) If not self, specify name_____________________
Insured Person's Employer_____________________________________and DOB________________

Emergency Contact______________________________________Phone #______________________

Do we have permission to leave medical information on the voicemail of the phone numbers you provided? If yes, which ones?
____
Do we have permission to discuss your personal medical information with other individuals ? If yes, whom?
____

Signed ____**Date** __________________
(Signature of patient, parent, guardian or power of attorney)

Pt Name____ **Date**______________________ **Acct#**____________________

PATIENT HISTORY OF PRESENT ILLNESS

Purpose of this visit ____

Symptoms____

For how long?____

Surgical/Hospitalization History

DATE	PROCEDURE/REASON FOR HOSPITALIZATION?	COMPLICATIONS?	PROBLEMS W/ANESTHESIA?

When was your most recent:

Colonoscopy__________________________________ Location____

EKG__________________________________ Location____

Bone density test__________________________________ Location____

Chest X-Ray_______________________________ Location____

****FOR WOMEN ONLY****

Age of 1st menstrual cycle____________ Age of menopause____________ Date of last pap smear____________________________________

Age of 1st pregnancy____________ # of pregnancies____________ Date of last mammogram_____________________________________

Do you have any relatives with breast cancer?_____________ If yes, whom?____

DO YOU HAVE: (PLEASE CHECK ALL THAT APPLY)

GENERAL

( )Good general health lately
( )Recent weight change
( )Fever/fatigue/headaches

EYES

( )Blurred or double vision
( )Eye disease or injury
( )Wear glasses or contacts

EAR, NOSE, MOUTH, THROAT

( )Sore throat /Laryngitis
( )Hearing loss or ringing
( )Earaches or drainage
( )Chronic sinus problems
( )Nose bleeds Bleeding gums
( )Swollen glands in neck
( )Bad breath/bad taste in mouth

ENDOCRINE

( )Glandular, hormone problems
( )Excessive thirst
( )Heat/cold intolerance
( )Change in hat/glove size

CARDIOVASCULAR/HEART

( )Heart trouble
( )Chest pain/shortness of breath
( )Swelling of feet/ankles/hands

RESPIRATORY

( )Chronic/frequent cough
( )Spitting up blood
( )Wheezing

GASTROINTESTINAL

( )Loss of appetite
( )Change in bowel pattern
( )Nausea/vomiting
( )Frequent diarrhea
( )Abdominal pain
( )Rectal bleeding/blood in stool

GENITOURINARY

( )Kidney stones
( )Frequent urination
( )Burning/painful urination
( )Blood in urine
( )Change in force/stream of urine
( )Incontinence/dribbling
( )Sexual difficulty
( )Male-testicular pain
( )Female-painful/irregular periods or unusual vaginal discharge

MUSCULOSKELETAL

( )Joint pain/stiffness/swelling
( )Joint/muscle weakness/cramping
( )Back pain
( )Cold extremities
( )Difficulty walking

SKIN

( )Rash or itching/excessive dryness
( )Change in skin color/hair/nails
( )Varicose veins

NEUROLOGICAL

( )Paralysis
( )Head injury
( )Lightheaded/dizzy
( )Convulsions/seizures/tremors
( )Numbness/tingling

HEMATOLOGIC/LYMPHATIC

( )Slow healing
( )Bleeding/bruising easily
( )Anemia
( )Plebitis
( )Past transfusion
( )Enlarged glands

Pt Name____ **Date**______________________ **Acct#**__________

PATIENT CURRENT MEDICATION LOG

Please include prescription and over-the-counter/herbal medications

Name of Medication	Current Dosage	Frequency

ALLERGIES TO MEDICATIONS:____

____

Social History

What is your occupation? ____

Do you take aspirin? (YES) (NO) How much/Frequency____

Do you smoke cigarettes/tobacco? (YES) (NO) How much/frequency_______________________________

Do you drink alcohol? (YES) (NO) How much/Frequency____

Do you use recreational drugs? (YES) (NO) How much/frequency_________________________________

Family Medical History – Please list any immediate family members with chronic illness/disease

RELATIONSHIP TO YOU	LIVING	DECEASED	AGE	NAME OF ILLNESS/DISEASE/CONDITION

Relatives with colon cancer____