Family Care Partners - Patient Information Form

(Please Print)

Patient Info

Last Name:	Home Phone:
First Name: M.I.:	Work Phone:
Address:	Cell Phone:
City, State, Zip:	Date of Birth:
Sex: (circle one) Male / Female	Social Security #:
Employer/School:	E-mail Address:
Occupation:	Marital Status: M S D W (Circle One)
Race: (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / Other (Unknown/Unspecified) / White	
Ethnicity: (circle one) Hispanic or Latino / Not Hispanic or Latino / Unknown or Declined	
Language:	
Primary Care Provider:	Phone:
Referring Provider:	Phone:
How did you hear about us?	

Policyholder Info: (Self/Parent/Spouse)

Last Name:	Home Phone:
First Name: M.I.:	Work Phone:
Address:	Social Security #:
City, State, Zip:	Date of Birth:
Employer:	Marital Status: M S D W (Circle One)

Local Friend/Relative Not Living with You:

Name:	Relationship:
Address:	
Phone #:	

PLEASE PROVIDE COPIES OF YOUR INSURANCE CARDS AND FILL OUT INFO BELOW:

Insurance Info: *Primary*	*Secondary*
Name:	Name:
ID#:	ID#
Group#:	Group#:
Phone #:	Phone #:
Address:	Address:
In Network?	In Network?
Date Info Updated:	Date Info Updated:
Point of Contact:	Point of Contact:
Authorization Requirements:	Authorization Requirements:
Copayment:	Copayment:
Effective Dates:	Effective Dates:

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Patient Name:	Date Of Birth:

Patient Medical History

Please circle all that apply to your health history

Allergies, Asthma	Yes / No	Diabetes	Yes / No
Anemia	Yes / No	Arthritis	Yes / No
Bleeding Tendencies	Yes / No	Gout	Yes / No
Heart Trouble	Yes / No	Peptic Ulcer	Yes / No
High Blood Pressure	Yes / No	Kidney Problem	Yes / No
Stroke	Yes / No	Alcohol or Drug Problem	Yes / No
Cancer	Yes / No	Emotional Problem	Yes / No
Glaucoma	Yes / No	Other:	

Patient Surgical History

Please circle all that apply to your health history

Mastectomy: *circle: (both breasts) (left breast) (right breast)	Dates:	Tonsillectomy:	Date:
Appendectomy	Date:	Other Surgery:	Date:
Hysterectomy: *circle one:(cervix)(uterus) (fallopian tubes)(ovaries) (unknown)	Date:	Other Surgery:	Date:
Vasectomy	Date:	Other Surgery:	Date:

Please list any other hospitalizations:

Reason:	Date:
Reason:	Date:

Family Medical History

Please Circle any that apply

MEDICAL HISTORY	RELATION TO YOU (Mother, Father, Etc)	DECEASED?	IF YES, AGE
Anemia		YES / NO	
Bleeding Tendencies		YES / NO	
Heart Trouble		YES / NO	
High Blood Pressure		YES / NO	
Stroke		YES / NO	
Cancer (Type:)		YES / NO	
Glaucoma		YES / NO	
Diabetes		YES / NO	
Arthritis		YES / NO	
Gout		YES / NO	
Peptic Ulcer		YES / NO	
Kidney or Bladder Problem		YES / NO	
Alcohol or Drug Problem		YES / NO	
Emotional Problem/Nervous Breakdown		YES / NO	

Social History/Habits

Tobacco: Cigarettes________ Pipes ______ Cigars ______ Amount/Day_____ No. Years___ QUIT? Yes / No
Alcoholic Beverages: Usually Daily______ Weekends______ Never _____ Type ____________ AMT______
Coffee/Caffeine: Cups/Glasses Per Day____________ Exercise: Type____________ Frequency:_________

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Patient Review of Systems:

Please mark any symptoms that you are currently having below by checking the box.

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Weight loss
- ☐ Other__________

Respiratory
- ☐ Cough
- ☐ Dyspnea(shortness Of breath)
- ☐ Hemoptysis (spitting up of blood)
- ☐ Known TB exposure
- ☐ Wheezing
- ☐ Other_______________

Genitourinary
- ☐ Dysuria
- ☐ Hematuria(blood in Urine)
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Other____________

Neurological
- ☐ Dizziness
- ☐ Focal weakness
- ☐ Difficulty walking
- ☐ Headaches
- ☐ Memory loss
- ☐ Nervousness
- ☐ Paresthesia (numbness)
- ☐ Seizures
- ☐ Slurred speech
- ☐ Other________

Musculoskelatal
- ☐ Back Pain
- ☐ Body Aches
- ☐ Calf tenderness
- ☐ Joint Swelling
- ☐ Painful Joints
- ☐ Other__________

HEENT
- ☐ Bleeding Gums
- ☐ Dysphagia (trouble Swallowing)
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Epistaxis (bleeding of The nose)
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Mouth Ulcers
- ☐ Ringing in ears
- ☐ Snoring
- ☐ Visual loss

Cardiovascular
- ☐ Chest Pain
- ☐ Edema (swelling)
- ☐ Leg Swelling
- ☐ Palpitations
- ☐ Syncope (fainting)
- ☐ Other_________

Reproductive
- ☐ Abnormal PAP
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Dysmenorrhea (Painful Cramps)
- ☐ Dyspareunia (painful intercourse)
- ☐ Hot Flashes
- ☐ Menorrhagia (abnormal bleeding)
- ☐ Vaginal discharge

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other__________

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Other____________

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Appetite changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hematemesis (vomiting Blood)
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting

Metabolic/Endocrine
- ☐ Goiter
- ☐ Increase in thirst
- ☐ Uncontrolled Hunger
- ☐ Other____________

Integumentary
- ☐ Hives
- ☐ Itching
- ☐ Mole changes
- ☐ Rash
- ☐ Ulcer
- ☐ Other__________

Immunological
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Hay Fever
- ☐ Other________________________

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Patient Name:_______________________________________ **DOB:**______________________________

Patient Allergies:
Please list any allergies to medications below

____

____

____

____

____

Patient Medications:
Please list any prescription or over the counter medications below:

MEDICATION NAME	STRENGTH	DOSAGE