PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ Middle _____

Sex: ☐ M ☐ F; DOB: _____ Age: _____ Social Security _____ Marital Status _____

Mailing Address: _____ City/State/Zip _____

Home Phone: _____ Cell Phone_____ Work Phone _____

EMAIL (this will be used for your Patient Portal Access):_____

Emergency Contact _____ Phone _____

Address _____ Relationship _____

Referred by:: ☐ Former Patient ☐ Referred by Family/Friend ☐ Newspaper ☐ Telephone Book☐ Movie theater ad ☐ Doctor

We are updating our records to comply with federal standards, please answer the following questions:

Race _____; Ethnicity: ___Hispanic/Latino; ___Non-Hispanic/Non-Latino; ___ Other: ___I do not wish to provide

Smoking Status: ____Current everyday smoker, ____Current some day smoker; ____Former smoker; ____Never smoker

If current or former smoker, at what age did you begin smoking?_____

MEDICAL HISTORY:

Do you have any medication allergies? If yes, what: _____

Are currently taking any medications: ☐ No; ☐ Yes-please list below (use back of this form is necessary

_____ _____ mg _____ _____ mg

_____ _____ mg _____ _____ mg

_____ _____ mg _____ _____ mg

Are you pregnant? _____; Number of children _____; Do you use: ____Alcohol, ____ Coffee, _____Tobacco

Past Medical History (circle): ☐ None ☐ Heart Dis. ☐ Cancer ☐ Diabetes☐ High Blood Pressure

☐ Stroke ☐ Lung Disease ☐ Other _____

Past Surgeries: _____

_____

Family Medical History (list relation M, F, MGM, MGF, PGM, PGF, Bro, Sis, A, U)

Heart Dis _____; Cancer _____; High BP _____

Stroke _____; Lung Dis _____; Other _____

FOR STAFF USE ONLY:

VITALS: Height: _____ **Weight:** _____ **Blood Pressure:** _____