<u>IIIA</u> ADULI HISTORT NEV	W PATIENT FO	Please complete this form an bring it with you to your vis
PLEASE BRING ALL MEDICATION(S) TO YO	UR APPOINTMENT.	Date:
Name:		Date of Birth:
(Last)	(First) (M	1iddle)
Birth Sex: Male Female Current Gender I Undifferentiated	, —	sclose 🗌 Female 🗌 Female-to-Male/Transgender Mal Male 🔲 Male-to-Female/Transgender Female
Preferred Pronoun: Decline to answer He, Him, H	His 🗌 She, Her, Hers 🗌 They	y, Them, Theirs 🔲 Ze, Hir 🗌 Other
Single Married Widow(er) Partner Dive	orced Who do you live	with? Alone Partner Family Other
Email:	Would y	you like to enroll in the Patient Portal? 🗌 Yes 🗌 N
Occupation:		
Emergency Contact Name:	Emergency Contact Ph	none:
Insurance:	Policy Nu	mber:
Having race, ethnicity and language information for all of our pat	ients helps us know them better.	
Race: 🗌 Alaskan Native or American Indian 🛛 Asian	Black or African American	Native Hawaiian or Other Pacific Islander
White Unknown Other		
Ethnicity: Hispanic or Latino Not Hispanic or La	tino 🗌 Declined	
Primary Language: 🗌 English 📋 Spanish 🗌 Other		
Are there any other languages spoken in the home? If yes, please	list:	
Preferred Pharmacy:		
Are there any other languages spoken in the home? If yes, please Preferred Pharmacy: Address: Phone:		
Preferred Pharmacy:	Fax:	
Preferred Pharmacy:	Fax: Do you take	
Preferred Pharmacy:	Fax: Do you take	your medications as directed? Yes No all medications to your visit in a bag.
Preferred Pharmacy:	Fax: Do you take *Please bring Name of Medi I	your medications as directed? Yes No a <i>all medications to your visit in a bag.</i> ication Dosage Times Per Day
Preferred Pharmacy: Address: Phone: Phone: Routine Check Up — No Symptoms Reason for Visit: (please list all current symptoms) 1. 2.	Fax: Do you take *Please bring Name of Medi 1 2	your medications as directed? Yes No g all medications to your visit in a bag. ication Dosage Times Per Day
Preferred Pharmacy:	Fax: Do you take *Please bring Name of Medi 1 2 3	your medications as directed? Yes No all medications to your visit in a bag. ication Dosage Times Per Day
Preferred Pharmacy: Address: Phone: Phone: Routine Check Up — No Symptoms Reason for Visit: (please list all current symptoms) 1. 2.	Fax: Do you take *Please bring Name of Medi 1 2 3 4	your medications as directed? Yes No a all medications to your visit in a bag. ication Dosage Times Per Day
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Preferred Pharmacy: Address: Phone: Phone: Reason for Visit: (please list all current symptoms) 1. 2. 3. Chronic Problems: 1. 2. 2.	Fax: Do you take *Please bring Name of Medi 1 2 3 4 5 6	your medications as directed? Yes No all medications to your visit in a bag. ication Dosage Times Per Day
Preferred Pharmacy: Address:	Fax: Do you take *Please bring Name of Medi 1. 2. 3. 4. 5. 6. Supplements /	your medications as directed? Yes No all medications to your visit in a bag. Times Per Day Times Per Day Times Per Day
Preferred Pharmacy: Address: Phone: Phone: Chronic Problems: I. 2. 2. 2. 2.	Fax: Do you take *Please bring Name of Medi 1 2 3 4 5 6 Supplements / 1	your medications as directed? Yes No all medications to your visit in a bag. ication Dosage Times Per Day

Reaction	Source	Reaction
	4	
	5	
	6	
		4

Have you ever had any of the following?

(If yes, enter date to those that apply)

TEST	Date
Eye Exam	
Dental Exam	
Cholesterol	
PPD (TB test)	
HIV test	
Hepatitis C	
Stool blood test	
Colonoscopy	
Bone density	
Chest X-Ray	
Heart Stress Test	
Blood transfusion	
MRI	
Sleep Study	
Other	

Surgical History Date	Surgical History Date					
Angioplasty						
Appendectomy	Hernia repair					
Arthroscopy of knee	Hip/Knee replacement					
Back surgery	Hysterectomy					
CABG (Heart bypass)	_ Why did you have a hysterectomy?					
Carpal tunnel release						
Cataract extraction	— Was your cervix removed? 🗌 Yes 🗌 N					
Colon resection	— Were your ovaries					
Colostomy	removed?					
Defibrillator	Did you have a vaginal					
Fracture						
Location:	LASIK					
Gallbladder out						
Gastric bypass	Small bowel resection					
Gastric Band						
Gastric Sleeve	Tonsillectomy					
	Pacemaker					
	Prostate surgery					
	Other					
	3					
cco Yes No Former	Recreational drug use					
garettes	Recreational drug use					
garettes per day	Recreational drug use Yes No Former Have you ever used IV drugs?					
garettes	Recreational drug use					
garettes per day	Recreational drug use Yes No Former Have you ever used IV drugs? Yes No					
garettes per day	Recreational drug use Yes No Former Have you ever used IV drugs? Yes No Personal safety					
garettes per day gars ewing Tobacco	Recreational drug use Yes No Former Have you ever used IV drugs? Yes No Personal safety Do you wear your seatbelt?					
garettes per day gars ewing Tobacco ould like to quit of use	Recreational drug use Yes No Former Have you ever used IV drugs? Yes No Personal safety Do you wear your seatbelt? Yes No					
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garettes per day gars ewing Tobacco ould like to quit of use quit al History	Recreational drug use Yes No Have you ever used IV drugs? Yes No Personal safety Do you wear your seatbelt? Yes No Do you have difficulty dressing yourself? Yes No					
garettes per day gars ewing Tobacco ould like to quit of use quit al History ou currently sexually active?	Recreational drug use Yes No Have you ever used IV drugs? Yes No Personal safety Do you wear your seatbelt? Yes No Do you have difficulty dressing yourself? Yes No Do you have difficulty carrying 10 pounds					

Other recent physician or hospital visits:

I._____

Social History (Check all that apply) Alcohol Use Yes No Former

Caffeine Yes No Amount/week

Frequency (Hours/week):

Types:

Years Drinking

Drinks per week

Туре

Quit date

Last drink

Coffee Pop/Soda

Other:

Energy drinks

Exercise Yes No

Have you experienced a fall in the last year? 🗌 Yes 🗌 N	o If yes, how many times have you f	fallen this year?			
Were you injured in the fall(s)? 🗌 Yes 🗌 No					
Over the past 2 weeks, how often have you been bothered by any of the following problems?					
Little interest or pleasure in doing things 🛛 🗌 Not at	all 🗌 Several days 🗌 More than ha	If the days 🗌 Nearly daily			
Feeling down, depressed or hopeless 🛛 Not at all 🗌 Several days 🗌 More than half the days 🗌 Nearly daily					
Do you work? 🗌 Yes 🗌 No 🗌 Retired					
Do you have a Living Will/Durable Power of Attorney? 🗌 Yes 🗌 No					
How many children do you have?					

If yes, when?

Personal and Family History (Check all that apply)

Unknown/Adopted

Check of that apply) HEDICAL CONDITION SELP RELATIVE MEDICAL CONDITION SELP RELATIVE Kiney stores \res MEDICAL CONDITION SELP RELATIVE Kiney stores \res \res MEDICAL CONDITION SELP RELATIVE Kiney stores \res	Personal and Family Histo	ry	Unknov	wn/Adopted				WHICH
urdle any items that were known Couse of death for relative Kidney disease Yes Yes metocal consortion self Relative WHICH ADD/ADHD Yes Yes Yes ADD/ADHD Yes Yes Yes ADD/ADHD Yes Yes Yes Alarbiner's Disease/Dementa Yes Yes Yes Alarbiner's Disease/Dementa Yes Yes Yes Anemia Yes Yes Others Yes Andrigis Yes Yes Yes Yes Andrigis Yes Yes Yes Yes Anthins Yes Yes Yes Yes Arthintis Yes Yes Yes Yes BrH (elarged prostate) Yes Yes Yes Yes Bood dlocase (vits to hematology Yes Yes Yes Yes Colon Yes Yes Yes Yes Yes Breast Yes Yes Yes Yes Yes Colon Yes Yes	Check all that apply)							RELATIVE
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Any other injuries:			_			o results and	date	
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