Referred by: Name:_____ TODAY'S DATE:_____

Patient Information Form (Please Print)

Primary Care Physician:

Have you been a patient of FirstChoice Family Care or any of our providers in the past? ☐ Yes ☐ No

PATIENT

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

Last | **First** | **MI** | **Date of Birth** | **Age**

Address | **City** | **State** | **Zip**

Sex: ☐Male ☐Female

Are you a student? ☐ Yes ☐ No

Street Address (if different from mailing) | **City** | **State** | **Zip**

Phone (Home) | **Name of Employer** | **Employer's Phone #**

Phone (Mobile) | **Employer's Address**

Preferred Method of Contact? ☐Home Phone ☐Mobile Phone

May we send appointment and treatment reminders via text and voicemail? ☐Yes ☐No

Email:

Spouse's Name | **Date of Birth**

ADDITIONAL INFORMATION

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific ☐Black ☐White ☐Hispanic ☐Other ☐Decline to Answer

Ethnicity: ☐Hispanic ☐Non-Hispanic | What Language do you prefer? ☐English ☐Spanish

Name of your Pharmacy | **Address**

City | **State** | **Zip** | **Phone #**

RESPONSIBLE PARTY

☐ Self
☐ Spouse
☐ Guardian
☐ Other

Last | **First** | **MI** | **Phone Number:**

Address

City | **State** | **Zip**

IN CASE OF EMERGENCY NOTIFY

Name | **Relation**

Address | **Phone #**

INSURANCE INFORMATION

Primary Insurance | **Address**

Policy Contract # | **Group #** | **City** | **State** | **Zip**

Name of Policy Holder | **Date of Birth**

Secondary Insurance | **Address**

Policy Contract # | **Group #** | **City** | **State** | **Zip**

Name of Policy Holder | **Date of Birth**

FIRSTCHOICE FAMILY CARE

Date:_____

PATIENT INFORMATION FORM

Patient's Name: _____ Guardian's Name (if under 18): _____

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL	
Medication or Other (Environmental)	**Reaction**

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Sibling(s)
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

Relationship	Cause of death	Age at death	Relationship	Cause of death	Age at death

YOUR HEALTH HISTORY

(Check if you have had any of the following)

	Abnormal Heart Rhythm		Chronic Pain		Heartburn/GERD		Obesity
	Allergies (any)		Chronic Kidney Disease		Heart Murmur		Osteoporosis
	Anemia		Depression		Hepatitis		Peripheral Vascular Disease
	Anxiety/Stress		Diabetes		High Blood Pressure		Seizures/Epilepsy
	Asthma		Emphysema/COPD		High Cholesterol		Sleep Apnea
	Arthritis		Gallbladder Disease		HIV/AIDS		Stomach Ulcers
	Atrial Fibrillation		Gout		Irritable Bowel Syndrome		Stroke
	Colitis or Crohn's Disease		Headaches/Migraines		Kidney Failure		Thyroid Disease
	Cancer		Heart Attack/Failure		Kidney Stones		

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician
Colonoscopy			
Cholesterol Screening			
Cardiac Stress Test			
Bone Density			
Mammogram			
Breast Exam			

Vaccine Type	Date
Tetanus (Td)	
Pneumonia	
Hepatitis B	
Influenza (Flu)	
Shingles	
Other	

OB/GYN HISTORY

Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/miscarriages	
Number of living children	

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO** **If yes, please describe**

NAME:_____ Date:_____

PAST SURGICAL HISTORY			
Date	**Surgery**	**Date**	**Surgery**

Please List Any Additional Medical Information:

_____

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ___ How many packs per day? ___

Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

Device	Yes/No	Device	Yes/No	Device	Yes/No
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

_____

LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

Name	Dose	Frequency	Ordering Provider

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

Specialty	Physician	Specialty	Physician	Specialty	Physician
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? **YES NO (circle one)**

If yes, please supply the office with a copy for your chart. If no, would you like one? **YES NO (circle one)**