

*Patient Label*

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

SS #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_ First Name Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language Spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you require an interpreter? Yes or No

**PHARMACY:**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male – Female

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Check here if address is the same as the patient.

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN INFORMATION: (*Fill this section ONLY if this registration is for a child under 18*)**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Preference: Home or Cell

Check here if address is the same as the patient. Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I give permission for my provider to contact me by home, work, or cell phone and or CircleHealth patient portal.**

**My preference is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Is it permissible for provider to leave a message regarding test results? YES or NO**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature and/or Parent/Legal Guardian Date**



Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Label*

**PATIENT MEDICAL HISTORY**

**Please complete the following questionnaire to the best of your ability. If there are any questions you prefer not answering leave them blank.**

**FAMILY HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Age ↓** | **Living** | **Deceased** | **Cause of Death** |
| Mother - |  |  |  |
| Father - |  |  |  |
| Sister - |  |  |  |
| Brother - |  |  |  |
|  |  |  |  |

Have any members of your **immediate family** had the following:

**Circle Answer**  **Relation**

Cancer:

* Breast Yes / No Mother – Father – Sister – Brother
* Colon Yes / No Mother – Father – Sister – Brother
* Ovarian Yes / No Mother – Father – Sister – Brother
* Uterine Yes / No Mother – Father – Sister – Brother

Diabetes Yes / No Mother – Father – Sister – Brother

Endometriosis Yes / No Mother – Father – Sister – Brother

Fibroids Yes / No Mother – Father – Sister – Brother

Heart Disease Yes / No Mother – Father – Sister – Brother

High Blood Pressure Yes / No Mother – Father – Sister – Brother

Kidney Disease Yes / No Mother – Father – Sister – Brother

Stroke Yes / No Mother – Father – Sister – Brother

DVT (Blood Clot) Yes / No Mother – Father – Sister – Brother

**MEDICATIONS:** Please list all prescription and non-prescription medicine

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES:** Please list all known allergies

|  |  |
| --- | --- |
| **Allergy** | **Reaction or Side Affect** |
|  |  |
|  |  |
|  |  |
|  |  |

**SURGICAL HISTORY AND HOSPITALIZATIONS:** Does not refer to pregnancies

|  |  |
| --- | --- |
| **Surgery / Hospitalizations / Name of Hospital** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |

**PERSONAL MEDICAL HISTORY**

**Immunizations:**  **Circle Answer Year**

Chicken Pox Yes / No \_\_\_\_\_\_\_\_\_\_

Measles – Mumps – Rubella (MMR) Yes / No \_\_\_\_\_\_\_\_\_\_

Hepatitis B Yes / No \_\_\_\_\_\_\_\_\_\_

Tetanus Yes / No \_\_\_\_\_\_\_\_\_\_

Gardasil Yes / No \_\_\_\_\_\_\_\_\_\_

Influenza (Flu) Yes / No \_\_\_\_\_\_\_\_\_\_

Have you ever had the following problems? **Circle Answer Year**

Anemia Yes / No \_\_\_\_\_\_\_\_\_\_

Bone Disease Yes / No \_\_\_\_\_\_\_\_\_\_

Cancer Yes / No \_\_\_\_\_\_\_\_\_\_

Depression/Anxiety Yes / No \_\_\_\_\_\_\_\_\_\_

Diabetes Yes / No \_\_\_\_\_\_\_\_\_\_

Heart Problems Yes / No \_\_\_\_\_\_\_\_\_\_

Hepatitis Yes / No \_\_\_\_\_\_\_\_\_\_

Hypertension Yes / No \_\_\_\_\_\_\_\_\_\_

Immune Disorder Yes / No \_\_\_\_\_\_\_\_\_\_

Kidney Problems Yes / No \_\_\_\_\_\_\_\_\_\_

Migraine Headaches Yes / No \_\_\_\_\_\_\_\_\_\_

Muscle Disease Yes / No \_\_\_\_\_\_\_\_\_\_

Thrombophlebitis Yes / No \_\_\_\_\_\_\_\_\_\_

Any Reactions to Anesthesia Yes / No \_\_\_\_\_\_\_\_\_\_

MRSA / VRE Yes / No \_\_\_\_\_\_\_\_\_\_

Blood Transfusions Yes / No \_\_\_\_\_\_\_\_\_\_

Are Blood Transfusions acceptable to you? Yes / No

**PREGNANCY HISTORY:** **Please list ALL pregnancies OR new pregnancies since last visit.**

**How many times have been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many children have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Month/Year** | **Place of Delivery** | **Length of Pregnancy** | **Type of Delivery** | **Complications** | **Gender** | **Birth Weight** | **Present Health** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**MENTRUAL HISTORY PAPSMEAR / MAMMOGRAM HISTORY**

Do you still have a period? Y / N Date of last pap? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not, age at which you stopped? \_\_\_\_\_\_ Have you ever had an abnormal pap: Y / N Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Age of first menses? \_\_\_\_\_\_ Date of last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with your periods? Y / N Have you ever had an abnormal mammogram? Y / N Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**CONTRACEPTION**

Smoker? Y / N Never Former

Are you currently sexually active? Y / N Alcohol? Y / N Never Frequency? \_\_\_\_\_\_\_\_\_\_\_\_

Current sexual partner? Male or Female Recreational drugs? Y / N Frequency? \_\_\_\_\_\_\_\_\_\_

Method of birth control currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seat belt use? Y / N Exercise? Y / N Frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you safe at home? Y / N

Any history of abuse or violence in your relationships? Y / N

Form: B-1, 1/10/2020