**NEW PATIENT QUESTIONNAIRE**

**Name (Last, First, Middle Initial)** Age **Birthdate**   **Sex**

M F

**Race Marital Status Occupation Email address**

**How were you referred to us? Please place a X next to your selection**

**Google  Web MD  Health Grades  Internet  Physician**

**Family/ Friend  Medstar Health  Patient  Vitals.com**

**Please tell us your Primary Care Physician Name**

**Primary Care Physician First and Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like todays visit information to be sent to any physician other**

**than those listed above?** **Yes**  **No**

**Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe the reason for your appointment today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Contact Information Form**

**PATIENT’S FULL NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**PATIENT’S SS#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PATIENT’S DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOME PHONE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORK PHONE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE COMPANY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY NUMBER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME OF INSURED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP TO PATIENT AND DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE COMPANY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY NUMBER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME OF INSURED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP TO PATIENT AND DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY NAME : \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY TELEPHONE# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT RELATIONSHIP:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT PHONE NUMBER**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPOUSE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPOUSE CONTACT INFORMATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Policy**

***Billing through Insurance***

I GIVE **ANGELA JONES MD LLC** AND ITS AGENT THE RIGHT TO FILE INSURANCE CLAIMS IN MY BEHALF FOR OFFICE VISITS, HOSPITALIZATIONS OR ANY OTHER SERVICES PROVIDED BY THE PHYSICIANS OR THE STAFF OF **ANGELA JONES MD LLC**.

I UNDERSTAND THAT, IT IS MY DUTY TO PROVIDE **ANGELA JONES MD LLC** AND ITS AGENTS WITH THE CORRECT AND UPDATED INSURANCE CARD AND ALL THE NECESSARY INFORMATION TO FILE SUCH CLAIMS.

**I UNDERSTAND THAT, IF MY INSURANCE COMPANY DOES NOT PAY FOR SUCH CLAIMS WITHIN 45 DAYS, I AM RESPONSIBLE AND WILL PAY THE BALANCE WITHIN 45 DAYS AFTER THE DATE OF SUCH VISIT.**

I UNDERSTAND THAT IF I AM INSURED BY A PLAN THAT **ANGELA JONES MD LLC** DOES NOT HAVE A PRIOR ARRANGEMENT WITH, A CLAIM WILL BE SENT TO MY INSURANCE COMPANY ON AN UNASSIGNED BASIS. THIS MEANS THE INSURER WILL SEND THE PAYMENT DUE DIRECTLY TO ME. THEREFORE, **ANGELA JONES MD LLC** CHARGES FOR MY CARE ARE DUE AT THE TIME OF SERVICE.

***Usual and Customary Rates***

WE ARE COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS AND WE CHARGE WHAT WE BELIEVE TO BE REASONABLE AND CUSTOMARY FEES FOR OUR REGION AND SPECIALTY.

***Co-Pay Charges***

**I UNDERSTAND THAT ANGELA JONES MD LLC HAS MADE PRIOR ARRANGEMENTS WITH MANY INSURANCE COMPANIES AND OTHER HEALTH PLANS TO ACCEPT AN ASSIGNMENT OF BENEFITS. MY INSURANCE COMPANY WILL BE BILLED FOR SERVICES RELATED TO OFFICE VISITS AND/OR HOSPITAL STAYS, AND I WILL BE REQUIRED TO PAY A COPAYMENT AT THE TIME OF THE OFFICE VISIT.**

***Past-Due Balances***

**OVERDUE BALANCES ON PATIENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY. LEGAL FEES WE MAY INCUR TO SECURE PAST DUE BALANCES WILL BE ADDED TO YOUR ACCOUNT.**

***Returned Checks or Cancelled Credit Card Payments***

FOR CHECKS RETURNED TO US AS UNPAID BY YOUR BANK AND FOR CREDIT CARD TRANSACTIONS DECLINED OR CANCELLED BY YOUR CARD COMPANY, WE WILL CHARGE A $50.00 FEE.

***No-Show Fee***

**I AM REQUIRED TO CONTACT THE OFFICE IF I AM UNABLE TO KEEP MY APPOINTMENT. IF THE OFFICE DOES NOT RECEIVE NOTIFICATION FROM ME TO CANCEL OR RESCHEDULE APPOINTMENTS THERE WILL BE A $25 FEE**.

Patient or Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_** Date\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_**Date\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIVACY POLICY**

I understand that the patient’s health information is private and confidential. I understand that ***Angela Jones MD LLC****,* work very hard to protect the patient’s privacy and preserve the confidentiality of the patient’s personal health information.

I understand that ***Angela Jones MD LLC****,* may use and disclose the patient’s personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations [In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.].

***Angela Jones MD LLC*** has a detailed document called the “Notice of Privacy Practices”. It contains more information about the policies and practices protecting the patient’s privacy and is attached to this Acknowledgment. I understand that I have the right to read the “Notice” before signing this Acknowledgment.

***Angela Jones MD LLC***may update this Acknowledgment and “Notice of Privacy Practices”. If I ask, ***Angela Jones MD LLC*** will provide me with the most current “Notice of Privacy Practices.”

Within this “Notice of Privacy Practices” is contained a complete description of my privacy/confidentiality rights. These rights include, but aren’t limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

***Angela Jones MD LLC*** has established procedures, which help them, meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist ***Angela Jones MD LLC*** by following these procedures if I choose to exercise any of my rights described in the “Notice of Privacy Practices”.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_**Date\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_** **Date of Birth**\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT RECORD OF DISCLOSURE**

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s home.

**I wish to be contacted in the following manner (check all that apply):**

***Home telephone #*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Written communication***

\_\_\_\_ leave message with detailed information \_\_\_\_\_ can mail to my home address

\_\_\_\_ leave message with call-back number only \_\_\_\_\_can mail to my work/office address

***Email Address­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History**

Please indicate if you have ever been **diagnosed** with any of the following conditions.

If Yes, please give an explanation. **Please place an X next to your answer.**

**SYSTEM YES NO PATIENT COMMENTS**

***CARDIOVASCULAR***

**Irregular Heartbeat**

**Blood Clotting Disorder**

**Heart Failure**

**High Cholesterol**

**Heart Attack/Angina**

**High Blood Pressure**

**Prosthetic/Artificial Heart Valve**

**Blockage of Blood Vessels**

***GASTROINTESTINAL/***

***GENITOURINARY/***

***RESPIRATORY***

**Stomach Ulcers**

**Liver Disease/Hepatitis**

**Kidney/Bladder Disease**

**Lung Disease**

**Tuberculosis**

***OTHER***

**Alcohol/ Drug Abuse**

**Cancer**

**Diabetes**

**Immune System Disorder**

**Thyroid Disease**

**Sexually Transmitted Disease**

**OTHER PAST MEDICAL HISTORY (**Please list all medical conditions not mentioned above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS OPERATIONS/HOSPITALIZATIONS:**

**Date Hospital Problem/Operation**

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

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

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

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

**CURRENT MEDICATIONS (Please list all medications, i.e. over-counter medications and herbal meds)**

**Medication and Dosage Medication and Dosage**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergy History**

Have you **ever had an allergic reaction** to any medication?  Yes  No If yes, please list all medication names and reaction.

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

**Social History**

Birthplace: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Highest Grade completed in School: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have **you ever smoked** cigarettes: Yes  No

If yes, how much **do you currently** smoke per day?  ½ pack 1 pack 2 packs > 2 packs

If you **previously smoked**, how long ago did you quit?  1 year 1-5 years > 5 years

How **many years did you** smoke? \_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often/much? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Yes No If yes, how much? Rarely Occasionally >3 times/week

Dietary Restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

*Family Member* ***Current Age (or age at death) List Any Medical Problems***

Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many Siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How many Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

*Have you experienced any of the following symptoms?* ***Please circle Yes, No, or Unknown. If yes, please give an explanation.***

**

**\*I have truthfully to the best of my knowledge, included all of the information requested above.**

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

**Patient or Guardian Signature Date**