Stuart Family Practice Center

PATIENT INFORMATION

DATE_____ SOCIAL SECURITY_____

LAST NAME_____ FIRST NAME_____

ADDRESS_____

CITY _____ STATE_____ ZIP_____

HOME PHONE NUMBER_____ WORK_____ CELL_____

HOW DO YOU PREFER TO BE CONTACTED? E-MAIL_____ TELEPHONE_____ MAIL_____

DATE OF BIRTH_____ AGE_____ MALE_____ FEMALE_____

MARITAL STATUS: M____D____S____W____ RACE_____ ETHNICITY_____

EMPLOYER_____ TELEPHONE_____

EMPLOYER ADDRESS_____

EMAIL ADDRESS_____

PREVIOUS PHYSICIAN_____

INSURANCE INFORMATION

PRIMARY POLICY HOLDER (if other than self) _____

PRIMARY POLICY HOLDER'S DOB (if other than self) _____

PRIMARY POLICY HOLDER'S SOCIAL SECURITY NUMBER (if other than self) _____

EMERGENCY CONTACT INFORMATION

NAME_____ RELATION_____

PHONE NUMBER_____ ALT PHONE NUMBER_____

Patient Name:_____ Date of Birth:_____

Please list drug Allergies and reaction:_____

_____

Why are you here to see the doctor? _____

_____

I. **Medical History**: (Circle below only the condition that you know that you have)

ENT: Allergies / Deafneass / Glasses / Glaucoma / Hay fever / Nosebleeds / Postnasal drip / Ringing in the ears / Sinusitis

Lungs: Asthma / COPD / Coughing blood / Cystic Fibrosis / Emphysema / Frequent Chest Infections / Persistent cough / Pleurisy / Pneumonia / Shortness of breath / Sleep Apnea

Heart: A Fib / CHF / Chest Pains / DVT / Enlarged Heart / Fluttering / Heart Attack / Heart trouble / High blood pressure / High Cholesterol / Irregular Heart Beat / Murmurs / Severe Swelling / Stroke

Intestines: Abnormal colonoscopy / Blood in or Black Bowel Movements / Cirrhosis / Difficulty swallowing / Gallbladder Trouble / Hemorrhoids / Hepatitis / Indigestion / Liver Disease / Ulcer / Vomiting Blood / Yellow or Jaundice

Kidneys: Diabetes / Painful urination / frequent urination / Blood in urine / Kidney Stones / Loss of control with cough or laugh / Prostate trouble in men / Do you have impotency or ejaculation problems

Nervous System: Blurred Vision / Convulsions / Epilepsy / Fainting / Headaches / Head injury / Paralysis / Persistent Numbness

Woman Services: Abnormal Pap / Pain in periods / Miscarriages/ Abnormal mammogram / Osteoporosis
Menstrual periods began at age_____ ceased at age_____
Number of pregnancies_____ Number of births_____

II. Have you ever had any surgeries in your life time (please listy any)? _____
_____
_____

III. Any Pertinent hospitalizations? _____
_____
_____

Patient Name:_____ Date of Birth:_____

IV. Family History:

Mother: __alive what is her health status?_____
__deceased what age?____ cause of death?_____
Father: __alive what is his health status?_____
__deceased what age? ____cause of death?_____

V. Social History:

1. Do you smoke Y___N____ How Much ____ For How Long_____
Have you ever smoked Y__N__ How Much___ For How Long____
When did you stop smoking? _____ (Years/Months)

2. Do you drink alcohol Y__N__ How Much_____ How Long_____
3. Have you ever drank alcohol Y__N__ How Much_____ How Long_____
When did you stop drinking alcohol?_____ (years/months)

4. Do you have a history of Alcoholism Yes_____ No_____

5. Do you have a history of Drug Abuse (including prescription drugs) Yes_____ No_____

If so what? _____

VI. Medication's you are currently taking (including vitamins and supplements)

Medication	Dose	Frequency

Health Maintenance

Please fill out to the best of your ability we Will go over it with you!

Preventive Services	Yes/No	When/Where
Colorectal Disease Screening	*******	
Colonoscopy		
Stool FBOT		
Diabetes Screening and Management	*******	
HgbA1c		
UA Microalbumin		
Eye exam within a year		
Foot doctor within a year		
Have you seen/had a	*******	
Eye specialist within a year		
Mammogram		
Pap Smear		
Bone Density		
Prostate Cancer Screening		
Immunization History	*******	
Flu Vaccine		
Pneumococcal		
Tetanus		
PPD		
Zoster (Shingles)		