PATIENT INTAKE AND HISTORY FORM

(Please print)

Name_____________________________________ **Date of Birth** ____________

<u>Race</u>: □ American Indian or Native Alaskan □ Asian □ Black/African-American
□ Native Hawaiian or Other Pacific Islander □ White □ Refused to report/Unreported

<u>Ethnicity</u>: □ Hispanic or Latino □ Non-Hispanic or Latino
□ Refused to Report/ Unreported □ Undefined

<u>Primay Language Spoken:</u> ____

<u>Preferred Local Pharmacy</u>: ____
(pharmacy name) (address or cross streets)

Do you use a mail order pharmacy? ____________ If so please be sure we have your pharmacy provider information and a copy of your prescription drug card.

<u>Mail Order Pharmacy</u>: ____

Reason(s) for coming to the doctor today:

	Reason 1	Reason 2
Reason for Today's Visit		
Timing/Onset: When did symptoms first occur?		
Duration: Frequency of Symptoms		
Characterized as/Severity: Describe the severity of the symptoms/pain.		
Associated Signs and Symptoms: What makes the condition better/worse?		
Has a previous provider provided treatment?	Name: Phone:	Name: Phone:

Personal History:

List known allergies (including medication allergies): □ No Known Allergies

____

____

____

List significant childhood illnesses or surgeries (continue on back if necessary):

Illness *Date(s) or Age*

____

____

____

List all injuries (continue on back if necessary):

Injuries *Date(s)*

____

____

____

Have you been diagnosed with any of the following (currently or in the past)?

___ Heart disease	___ Kidney problems	___ Stroke
___ Seizure disorder	___ Thyroid problems	___ Arthritis
___ High blood pressure	___ Glaucoma	___ Diabetes
___ Obesity	___ High Cholesterol	___ Ulcer(s)
___ Gout	___ Arthritis	___ Cancer
___ Acid reflux	___ Other bone problem	___ Liver disease
___ Depression	___ Psychiatric disorder	___ Cataracts
___ Pneumonia	___ Emphysema	___ Asthma

List any other medical condition(s) you have had (do not include common colds or flu). Include date of initial diagnosis if possible: ___________________________

____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Children: Girl(s)______ Boy(s) ______ □ Living at Home? □ Over 18 yrs old

Indicate your tobacco use as follows: □ Have never smoked
□ Current every day smoker □ Current some days smoker □ Former smoker
□ cigarettes □ cigars □ pipe □ chew □ snuff □ other _______________

Are you exposed to “second-hand” smoke by living with someone who smokes even though you do not? ____

Do you have pets/animals in the home? _________________________________

Do you drink alcohol?____If you do, how much do you drink per day or per week?
____

Do you drink beverages with caffeine? __________________________________

How much exercise do you get? □ none □ a little □ some □ regular exercise

List any nutritional supplements / alternative remedies (vitamins, minerals, herbs, etc.) that you are currently taking. ____
____
____

List places you have traveled in the past two years—particularly to areas outside of the continental U.S. ____
____

<u>Family History:</u> Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Write ‘**F**’ for father, ‘**M**’ for mother, ‘**Br**’ for brother, or ‘**Sis**’ for a sister beside each condition that applies:

___ Heart disease
___ Kidney problems
___ Stroke
___ Cancer
___ High blood pressure
___ Diabetes
___ Obesity
___ Depression
___ Alcoholism
___ Early Senility
___ Other psychiatric disorders

Do you have an Advanced Directive/Living Will? ___________________________

If not, do you want further information about a Living Will? __________________

REVIEW OF SYSTEMS

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:
- ❑ Chills
- ❑ Fever
- ❑ Fatigue
- ❑ Mood Swings
- ❑ Night Sweats
- ❑ Recent Unexpected Weight Loss

Respiratory:
- ❑ Shortness of Breath
- ❑ Snoring
- ❑ Chronic Wheezing
- ❑ Chronic Cough
- ❑ Coughing up Blood
- ❑ Excessive Phlegm

Musculoskeletal:
- ❑ Arthritis
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Joint Stiffness
- ❑ Muscle Weakness
- ❑ Muscle Aches and Pains

Endocrine/Glands:
- ❑ Appetite Changes
- ❑ Cold Intolerance
- ❑ Excessive Thirst
- ❑ Sexual Dysfunction

Skin:
- ❑ Rash
- ❑ Itching
- ❑ Chronic Dry Skin
- ❑ Changes in a Wart or Mole
- ❑ Wound not healing

Neck:
- ❑ Neck Mass or Swelling
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Swollen Glands

Cardiovascular:
- ❑ Chest Pain
- ❑ Fainting/Blacking Out
- ❑ Shortness of Breath
- ❑ Swelling of Extremities

Neurological:
- ❑ Headaches
- ❑ Unable to Move Parts of Your Body at Times
- ❑ Difficulty Speaking
- ❑ Numbness/Tingling Sensations
- ❑ Seizures/Convulsions
- ❑ Tremors/Shaking Hands
- ❑ Fainting Spells
- ❑ Dizziness/Vertigo

Head, Eye, Ear, Nose & Throat:
- ❑ Blurred Vision or Double Vision
- ❑ Eye Redness or Irritation
- ❑ Eye Discharge
- ❑ Decreased Vision
- ❑ Sensitivity to Light
- ❑ Earache
- ❑ Ringing in Ears
- ❑ Decreased Hearing
- ❑ Nose Bleed(s)
- ❑ Decreased Sense of Smell
- ❑ Decreased Sense of Taste
- ❑ Nasal/Congestion or Pain
- ❑ Sore Throat
- ❑ Hoarseness

Gastrointestinal:
- ❑ Persistent Nausea/Vomiting
- ❑ Chronic Diarrhea
- ❑ Constipation
- ❑ Change in Appearance of Stool
- ❑ Bloody or Very Black Stools

Psychiatric:
- ❑ Feeling Depressed or Sad
- ❑ Memory Loss
- ❑ Trouble Thinking Though Things
- ❑ Change in Sleep Pattern
- ❑ Panic Attacks
- ❑ Suicidal Thoughts

Hematology:

- ❑ Abnormal Bleeding
- ❑ Anemia
- ❑ Bruise Easily
- ❑ Painful Lymph Nodes

Female Breast:

- ❑ Breast Mass
- ❑ Breast Pain
- ❑ Breast Swelling
- ❑ Nipple Discharge
- ❑ Nipple Pain

Female Genitourinary:

- ❑ Vaginal Discharge
- ❑ Vaginal Itching/Burning
- ❑ Uncontrolled Urination
- ❑ Painful Urination
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Pelvic Pain
- ❑ Painful Menstruation
- ❑ Urine Leaking

Male Genitourinary:

- ❑ Painful Urination
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Frequent Urination at Night
- ❑ Difficulty Getting and Maintaining an Erection
- ❑ Decreased Desire for Sexual Intercourse

Report any changes in your address, phone contact numbers, insurance, or emergency contact information to the front desk.

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

Primary Insurance Company ____

Secondary Insurance Company (if any) __________________________________

I, the undersigned, certify that I (or my dependent) has insurance coverage with the above named insurance company or other provider of benefits. I assign directly to Sumter Family Medicine, P.A. all benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all allowed charges that are not paid by my insurance company or other provider of benefits. I hereby authorize Sumter Family Medicine, P.A. to release all information necessary to secure payment of benefits. I authorize use of this signature on all insurance/claims submissions.

Signature_______________________________ Date ______________________
(Patient/Guardian/POA)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, V.2

I have received the Notice of Privacy Practices for Sumter Family Medicine, P.A., and I have been provided an opportunity to review it.

Signature ________________________________ Date ______________________
(Patient/Guardian/POA)