Patient Information – Medical History *(* ***\**** *required)*

|  |  |  |
| --- | --- | --- |
| **First:** | **Middle:** | **Last:** |

**Age:**     **Preferred Name or Nickname:**

**Patient Gender** \*: Male  Female

**Spouses Name:**

**Home address:**

**City:**       **State:**       **Zip:**

|  |  |
| --- | --- |
| **Birth Date:**  MM/DD/YYYY | /    / |

|  |  |
| --- | --- |
| **Home Phone:** | (     )     − |

|  |  |
| --- | --- |
| **Cell Phone:** | (     )     − |

|  |  |
| --- | --- |
| **Work Phone:** | (     )     − |

|  |  |
| --- | --- |
| **Patient Email:** |  |

**Work status:**  Employed  Unemployed  Retired  Disabled from work

|  |  |
| --- | --- |
| **Employer:** | **Occupation:** |

**Marital Status:**  Single  Married  Widowed  Domestic Partner  Divorced  Separated

**Insurance -** Primary

This is only needed for prior authorizations of referrals and prescriptions. Please keep this information up to date with our clinic.

**Do you have Medicaid or OHP \*?**  Yes  No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Insurance Company:** | | | | **Subscriber Name:** |
| **Birth Date:**  MM/DD/YYYY | /    / | | **Relationship to Patient:** | |
| **Policy number :** | |  | **Subscriber Employer:** | |

**Insurance -** Secondary

**Do you have Medicaid or OHP \*?**  Yes No

**Do you have Medicaid or OHP \*?**  Yes  No

|  |  |
| --- | --- |
| **Insurance Company:** | **Subscriber Name:** |

## Medical History

*PCP = Primary Care Provider (previous provider)*

**PCP Name:**

|  |  |  |  |
| --- | --- | --- | --- |
| **PCP Phone:** | (     )     − | **PCP Fax:** | (     )     − |

**Height \***       **Weight \***

**Do you use tobacco in any form?** Yes  No

**If yes, please list type, amount and frequency of use:**

**Do you use alcohol in any form?**  Yes  No

**If yes, please list type, amount and frequency of use:**

**Do you have medication allergies?**  Yes  No

**If yes, please list the medications**.

**Please list any past surgery and the year performed.**

**Please List All Medications.** *(Include all over the counter, herbal or natural supplements)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication Name | Dosage Amount | # Taken Daily | Ordering Provider | Start Date |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |
| 9 |  |  |  |  |  |
| 10 |  |  |  |  |  |
| 11 |  |  |  |  |  |
| 12 |  |  |  |  |  |
| 13 |  |  |  |  |  |
| 14 |  |  |  |  |  |
| 15 |  |  |  |  |  |

**Have you ever had or been diagnosed to have: (check all boxes that apply)**

|  |  |
| --- | --- |
| Cataracts | Kidney Disease |
| Glaucoma | Kidney Stone(s) |
| Asthma | Diabetes or Pre Diabetes |
| Allergies | Thyroid Disease |
| Stroke | Anemia Bleeding Disorders |
| Seizures/Epilepsy | Bone or Joint Disease |
| Hearth Attack or Angina | German Measles |
| Heart Disease | Rheumatic Fever |
| Heart Murmur | Chicken Pox |
| High Blood Pressure | Syphilis |
| Pneumonia TB/Lung Disease | Depression |
| Pleurisy | Frequent Infection |
| Jaundice or Liver Disease | Cancer |
| Ulcers | High Cholesterol |
| Digestive Disorder | Prostate Enlargement |
| Hemorrhoids | HIV |
| Auto Immune disease(s) (Lupus, Rheumatoid arthritis, etc.) | Lung Disease |
| Spine Disorders |  |

## Family Medical History

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age | Health (list significant illness) | Age at Death | If deceased, cause | Comments |
| Father |  |  |  |  |  |
| Mother |  |  |  |  |  |
| Siblings |  |  |  |  |  |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| Spouse |  |  |  |  |  |
| Children |  |  |  |  |  |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |

## Problem List

*Please check all problems you are experiencing*

**Constitutional Symptoms**

|  |  |  |
| --- | --- | --- |
| Good health lately | Yes | No |
| Recent significant weight change | Yes | No |
| Unusual fatigue or weakness | Yes | No |
| Frequent headaches | Yes | No |

**Eyes**

|  |  |  |
| --- | --- | --- |
| Good health lately | Yes | No |
| Recent significant weight change | Yes | No |
| Unusual fatigue or weakness | Yes | No |
| Frequent headaches | Yes | No |

**Ears/Nose/Mouth/Throat/Neck**

|  |  |  |
| --- | --- | --- |
| Do you wear hearing aids | Yes | No |
| Hearing loss or ringing in ears | Yes | No |
| Earaches or drainage | Yes | No |
| Chronic sinus problems or runny nose | Yes | No |
| Nose bleeds | Yes | No |
| Mouth sores | Yes | No |
| Bleeding gums | Yes | No |
| Sore throat/hoarseness or voice change | Yes | No |
| Lumps or swollen glands in neck | Yes | No |
| Difficulty swallowing | Yes | No |
| Neck Pain or stiffness | Yes | No |

**Cardiovascular**

|  |  |  |
| --- | --- | --- |
| Heart trouble | Yes | No |
| Chest pain or angina pectoris | Yes | No |
| Palpitations | Yes | No |
| Shortness of breath with walking or lying flat | Yes | No |
| Swelling feet, ankles or hands | Yes | No |
| Waking at night with shortness of breath | Yes | No |
| Heart attack | Yes | No |
| Heart murmur | Yes | No |

**Respiratory**

|  |  |  |
| --- | --- | --- |
| Chronic or frequent cough | Yes | No |
| Coughing or spitting up blood | Yes | No |
| Shortness of breath | Yes | No |
| Asthma or recurrent wheezing | Yes | No |

**Gastrointestinal**

|  |  |  |
| --- | --- | --- |
| Loss of appetite | Yes | No |
| Change in bowel movements | Yes | No |
| Nausea or vomiting | Yes | No |
| Painful bowel movements or constipation | Yes | No |
| Frequent diarrhea | Yes | No |
| Rectal bleeding or blood in stool | Yes | No |
| Stomach/abdominal pains or heartburn | Yes | No |
| Black or tarry stools | Yes | No |

**Genitourinary**

|  |  |  |
| --- | --- | --- |
| Frequent urination | Yes | No |
| Burning or pain on urination | Yes | No |
| Blood in urine | Yes | No |
| Change in force or strain when urinating | Yes | No |
| Incontinence or dribbling of urine | Yes | No |
| Sexual difficulties | Yes | No |
| **Men**: Testicular pain | Yes | No |
| **Women**: Painful periods | Yes | No |
| Irregular periods | Yes | No |
| Recurrent vaginal discharge | Yes | No |

**Menopausal since when:**       **Year of hysterectomy:**

**Number of pregnancies:**

**Number of deliveries:**       **Number of miscarriages:**

**Method of birth control:**

*(if applicable)*

**Date of last pap smear:**

**Date of last mammogram:**

**Musculoskeletal**

|  |  |  |
| --- | --- | --- |
| Joint pain (s) | Yes | No |
| Joint stiffness/swelling or warmth | Yes | No |
| Weakness of muscles or joints | Yes | No |
| Muscle pain or recurrent cramps | Yes | No |
| Back pain | Yes | No |
| Cold hands or feet | Yes | No |
| Difficulty in walking | Yes | No |

**Integumentary**

**(Skin/Breast)**

|  |  |  |
| --- | --- | --- |
| Rashes or itching | Yes | No |
| Change in skin color or moles | Yes | No |
| Change in hair or nails | Yes | No |
| Varicose veins | Yes | No |
| Breast pain | Yes | No |
| Breast lump | Yes | No |
| Breast discharge or rash | Yes | No |

**Neurological**

|  |  |  |
| --- | --- | --- |
| Frequent , recurring or increasing headaches | Yes | No |
| Light-headedness or dizziness | Yes | No |
| Convulsions, seizures of spasms | Yes | No |
| Numbness or tingling sensations | Yes | No |
| Tremors | Yes | No |
| Paralysis | Yes | No |
| Stroke | Yes | No |
| Head injury | Yes | No |

**Psychiatric**

|  |  |  |
| --- | --- | --- |
| Memory loss or confusion | Yes | No |
| Nervousness | Yes | No |
| Insomnia | Yes | No |
| Depression | Yes | No |

**Endocrine**

|  |  |  |
| --- | --- | --- |
| Glandular or hormone problem | Yes | No |
| Heat or cold intolerance | Yes | No |
| Excessive skin dryness | Yes | No |
| Excessive thirst or urination | Yes | No |
| Change in hand or glove size | Yes | No |

**Hematologic/Lymphatic**

|  |  |  |
| --- | --- | --- |
| Slow to heal after cuts or wounds | Yes | No |
| Bleeding or bruising tendency | Yes | No |
| Recurrent anemia | Yes | No |
| Swelling, warmth or tenderness of veins or history of phlebitis | Yes | No |

**Allergic/Immunologic (list reactions if applicable)**

|  |  |
| --- | --- |
|  | **Yes** |
| History of skin reaction or other adverse reaction to: |  |
|  |  |
| Penicillin or other antibiotic: describe reaction: |  |
|  |  |
| Morphine, Demerol or other narcotics reaction: |  |
|  |  |
| Novocain or other anesthetics reaction: |  |
|  |  |
| Aspirin or other pain remedies reaction: |  |
|  |  |
| Tetanus antitoxin or other serums: |  |
|  |  |
| Iodine, merthiolate or other antiseptic: |  |
|  |  |

**Other medication you react to:**

**Other known food allergies:**

***Type a question:***

***Is there any specific service and/or concern you would like to inquire about?***

I, the undersigned, certify that I (or my dependent) will **not** bill Medicare, Medicaid, OHP nor my provider for any services received at Nicc's Direct Primary Care.  I understand I am only considered a member of Nicc's Direct Primary Care if my monthly membership fee is current, that the information I have given today is correct to the best of my knowledge.  I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.  Submission of this form does not guarantee my acceptance as a patient of Nicc's Direct Primary Care.

***Signature***

Date:Click here to enter a date.