ProHealth Partners Patient Information Sheet

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Work Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Drivers License # _____ Date of Birth _____ Social Security # _____

Sex: __M __F Marital Status: □ S □ M □ D □ W □ Other _____ How did you hear about us? _____

Primary Care Physician _____ Primary Language _____

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial ____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

PHARMACY INFORMATION

Pharmacy Name _____ Address _____ Phone _____

Signature (Patient or Parent of Minor): _____ Date: _____

over

Patient Name: _____ Account #: _____

Date: _____ DOB: _____

Please take the time to fill out the following form so that we can be sure your medical history is accurate and complete! Thank you.

Check only what applies. Print Only.

Past Medical History

- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Transfusions
- ☐ CAD
- ☐ Cancer
- ☐ Cardiac Pacer
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Chicken Pox
- ☐ Cirrhosis
- ☐ Colitis
- ☐ COPD
- ☐ Chronic Renal Failure
- ☐ Crohn's disease
- ☐ CVA
- ☐ DVT
- ☐ Depression
- ☐ DM Type 1
- ☐ DM Type 2
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gastric ulcer
- ☐ Gastrointestinal Disease
- ☐ Gastroesophageal Reflux Disease
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insulin Pump
- ☐ Joint Pain
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney stone
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Progressive Neurological Disorder
- ☐ Pulmonary Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ STD
- ☐ Terminal Illness
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Tuberculosis
- ☐ Valvular Problems

Additional History:

Tobacco Assessment:

- □ Current every day smoker, Amount per day: _____
- □ Current some day smoker, Amount per day: _____
- □ Heavy tobacco smoker, Amount per day: _____
- □ Light tobacco smoker, Amount per day: _____
- □ Former smoker, Date Quit: _____
- □ Never smoker

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Social History:

Alcohol use:
- ☐ Non-drinker
- ☐ Occasional, Amount: _____
- ☐ Social drinker, Amount: _____
- ☐ Moderate alcohol consumption, Amount: _____
- ☐ Heavy alcohol consumption, Amount: _____
- ☐ Recovering alcoholic, Date Quit: _____

Caffeine use:
- ☐ 0 servings per day
- ☐ Occasional
- ☐ 1 serving per day
- ☐ 2 servings per day
- ☐ 3 servings per day
- ☐ 4+ servings per day

Recreational Drug use:
- ☐ Yes
- ☐ No

Sexually active:
- ☐ Yes, (circle one: men, women, or both)
- ☐ No

Occupation: _____

Educational level: _____

Marital status: _____

Race: _____

Native language: _____

Religion: _____

Physical abuse:
- ☐ Yes
- ☐ No

Domestic violence:
- ☐ Yes
- ☐ No

Condom Usage?
- ☐ Yes
- ☐ No

Falls Prevention (if >65 years of age):

- ☐ No falls or 1 fall without injury in the last year
- ☐ 2 or more falls or any fall with injury in the past year

OB/Gyn History (if female):

Last menstrual period: _____

Has menopause occurred:
- ☐ Yes
- ☐ No

History of abnormal pap smears:
- ☐ Yes
- ☐ No

History of ectopic pregnancy?
- ☐ Yes
- ☐ No

Birth control insertion date: _____

Birth control removal date: _____

Number of pregnancies: _____

Number of miscarriages: _____

Number of elective abortions: _____

Surgical/Procedural:

- ☐ No prior surgical history
- ☐ Appendectomy
- ☐ Breast Lumpectomy
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Subtotal Colectomy
- ☐ Cone Biopsy
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Gall Bladder
- ☐ Heart Surgery
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Laparoscopy
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Oophorectomy
- ☐ Ostomy
- ☐ Splenectomy
- ☐ Tonsil/Adenoidectomy
- ☐ Tubal Ligation

Additional Surgical History:

Hospitalizations:

Depression Screening:

Do you have little interest or pleasure in doing things?

- ☐ Not all days
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Have you felt down, depressed, or hopeless?

- ☐ Not all days
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Preventive Care:

	Date (Month & Year)		Date (Month & Year)
A1c% Test		Lipids	
Air Contrast Barium Enema		HPV Test	
Blood Glucose		HPV Vaccine (Completed Series)	
Bone Density		Last Complete Physical	
Carotid Ultrasound		Mammogram	
Chest X-ray		MMR Vaccine (Completed Series)	
Chlamydia Screening		Meningococcal Vaccine	
Colonoscopy		Pap Smear	
Coronary CTA		Pneumovax Vaccine	
Dilated Eye Exam		Prothrombin Time (PT)	
DTap Vaccine		PSA	
Echocardiogram		Pulmonary Function Tests	
Electrocardiogram		Routine Eye Exam	
EGD (Upper GI scope)		Stool Occult Blood	
Sigmoidoscopy		Stress Test	
Flu Vaccine		Td Vaccine	
Foot Exam Date		Tdap Vaccine, Adult	
Hepatitis A Vaccine (Completed Series)		Tuberculin PPD	
Hepatitis B Vaccine (Completed Series)		Urine Microalbumin	
HIV Test Date		Varicella	
INR		Zoster Vaccine	

FAMILY History: (please indicate whether Mother, Father, Brother, Sister, Son, Daughter, or Paternal/Maternal Grandparent)

- ☐ Adopted
- ☐ Unknown Paternal Hx
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Birth Defects
- ☐ CAD
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Cancer
  - Type: _____
- ☐ Denial of any knowledge of significant family history
- ☐ Unknown Maternal Hx
- ☐ Congenital Anomaly
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ GERD
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Births
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pulmonary Disease
- ☐ Stroke

Additional Family History:

Medications (please indicate Name, Dose, and Directions):

Allergies (please list reaction):