Primary Care Clinic
Adult Patient Demographics

Patient's Name: ____ Previous or Nickname: ____________________________

Sex: ☐ Male ☐ Female Social Security Number ________ - ________ - __________ Date of Birth**:** ________________________

Mailing Address: ____

City State Zip Code

Home Phone #: (______) ______ - __________May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_______) ______ - __________May we leave a message? ☐ Yes ☐ No

Email Address: ____

Race**:** ☐ White ☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Unknown ☐ Refuse to Report

Ethnicity**:** ☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown ☐ Refuse to Report

Marital Status: _________________ Primary Language**:** ☐ English ☐ Spanish ☐ Other: _____________ ☐ Refuse to Report

EMPLOYMENT:
Employment Status: _______________ Employer's Name: ________________________ Occupation: ________________________
Retirement Date: __________________Address: ____

City State Zip Code Phone #

INSURANCE INFORMATION:

Primary Insurance Company's Name: ____

Name as it Appears on the Card: ____

Cardholder's Date of Birth: _____ / _____ / ______________

Cardholder's Social Security #: ________ - ________ - ________

Member ID #: ___________________________________ Group Name or #: ________________________________

Secondary Insurance Company's Name: ____

Name as it Appears on the Card: ____

Cardholder's Date of Birth: _____ / _____ / _____________

Cardholder's Social Security #: ________ - ________ - ________

Member ID #: ___________________________________ Group Name or #: ________________________________

EMERGENCY CONTACT:
Name: ____ Relationship: ____________________________________

Home Phone #: (______) ______ - ______________________ Additional Phone #: (______) ______ - _______________

Patient Signature: ____ Date: _____ / ______/________

PAGOSA SPRINGS
Medical Center

Reviewed/Revised 03/23/2016, 11/04/2016

Patient Health History: Adult

Your answers on this form will help your healthcare team obtain an accurate history of your medical concerns and conditions. Please do your best to complete all four pages. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

Name: ________________________________ Date of Birth: ______________ Today's Date: _______________

Personal Medical History: Please indicate with an **X** if you have had the following:

Condition:	**X**	**Condition:**	**X**	**Condition:**	**X**
CARDIOVASCULAR		**BLOOD CONDITION**		**CANCER**	
Atrial Fibrillation		Anemia		Blood/ Leukemia	
Congestive Heart Failure		Blood Transfusion		Brain	
Heart Attack		Blood Clot		Breast	
High Cholesterol				Colon	
Hypertension		**EMOTIONAL/BEHAVIORAL**		Lung	
		Alcoholism		Ovarian	
EYES/EARS		Alzheimer's Disease		Prostate	
Blindness		Anxiety		Other:	
Cataract		Attention Deficit Disorder			
Glaucoma		Bipolar Disorder		**ENDOCRINOLOGY/RENAL**	
Hay Fever		Depression		Chronic Renal Failure	
Hearing Loss		Drug Use		Diabetes Type 1	
		Eating Disorder		Diabetes Type 2	
GASTROINTESTINAL		Memory Problems		Dialysis	
Celiac Disease		Post-Traumatic Stress Disorder		Kidney Disease/Kidney Stone	
Colitis		Schizophrenia		Thyroid Disorder	
Colon Polyps				Urinary Tract Infection-frequent	
Crohn's Disease (Granulomatous)		**MUSCULOSKELETAL**			
Diverticulitis		Arthritis		**NEUROLOGICAL**	
Gastrointestinal Bleeding		Back/Neck Injury		Migraine/Headaches	
GERD (heart burn/reflux)		Carpel Tunnel Syndrome		Seizure Disorder	
Hemorrhoid		Chronic Pain		Stroke	
Hepatitis		Gout		Tremor	
Irritable Bowel Syndrome		Osteoporosis			
Liver Disease				**OTHERS**	
Pancreatitis		**RESPIRATORY**		Autoimmune Disorder	
		Asthma		Erectile Dysfunction	
PREGNANCY		COPD (Emphysema)		Fibromyalgia	
Number of pregnancies:		Pneumonia		HIV	
Number of live births:		Pulmonary Embolism		Skin Condition	
		Respiratory Disorder			
		Sleep Apnea			
		Tuberculosis			

Current Medications: (include prescriptions, over the counter, supplements, vitamins, and herbs)

Name of Drug	Dose	Times Per Day	Reason	Prescribed By

Preferred Pharmacy:____

Allergies:

Source: (medications, pollens, food, animals, other)	Type of Reaction

Surgical History: Please indicate with an **X** in the appropriate box if the following procedure is applicable to you.

Surgical Procedure	X	Year	Surgical Procedure:	X	Year
Abdominal Surgery			Heart surgery		
Appendectomy (Appendix)			Hernia Repair		
Back Surgery			Hip Surgery		
Biopsy			Hysterectomy		
Breast Biopsy			Knee Surgery		
Breast Surgery			LEEP (Cervix Surgery)		
Colonoscopy			Ovary Removal		
Coronary Bypass			Sigmoidoscopy		
Coronary Stent			Sinus Surgery		
Cosmetic Surgery			Tonsillectomy		
EGD (Stomach Endoscopy)			Tubal Ligation		
Cataract			Other:		
Gallbladder Removal			Other:		

Family History: Please indicate with an **X** if a family member has one of the following conditions:

Condition	Mother	Father	Siblings	Grandparents
Cancer				
Diabetes				
Glaucoma				
Heart Disease				
High Blood Pressure				
Mental Illness				
Stroke				

LIFESTYLE:

Tobacco Use:

☐ Current

Type ☐ Cigarettes (packs day/week _____)
☐ Cigars/Pipe (times per day/week _____)
☐ Oral (times per day/week _____)
☐ Snuff (times per day/week _____)
☐ Other ________________________

Previous Treatment: ___________________________

Are you ready to change? ☐Yes ☐No

☐ Past (Cigarettes: packs day/week_____)
Other: ________________________

☐ Never

Recreational Drug Use:

☐ Current
☐ Past
☐ Never

Alcohol Use:

Do you ever consume alcoholic beverages? YES ☐ NO ☐

☐ 1-2 times a year ☐ 1-2 times a month ☐ 1-2 times a week ☐ 3-5 times a week ☐ Daily

If you answered yes, please complete the following 4 questions. If you answered no, skip to Immunizations.

Have you ever felt you should cut down on your drinking? YES ☐ NO ☐
Have people annoyed you by criticizing your drinking? YES ☐ NO ☐
Have you ever felt bad or guilty about your drinking? YES ☐ NO ☐
Have you ever taken a drink first thing in the morning to steady your nerves or get rid of a hangover? YES ☐ NO ☐

Immunizations: Please check off any vaccinations you have had, please add the year if known.

Vaccination:	Year:	Vaccination:	Year:
Flu/Influenza		Pneumonia	
Hepatitis A		Shingles	
Hepatitis B		Tetanus	
HPV		Tetanus w/Pertussis	
MMR		Varicella (Chicken Pox)	
Meningitis		Other:	

Have you had any of the following screening tests?

Screening test/Other test	**Date**	**Location**	**Result (please circle)**
Colonoscopy			Normal Abnormal
Dexa (Bone Density) Scan			Normal Abnormal
Mammogram			Normal Abnormal
Pap Smear			Normal Abnormal
Lipid Panel			Normal Abnormal
Aortic Aneurysm			Normal Abnormal

Within the last two weeks, how often have you been bothered by the symptoms listed below?

Feeling Down, Depressed, Hopeless
☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day

Little Interest or Pleasure in Activities
☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day

Have you ever been physically or emotionally abused by a partner? ☐ YES ☐ NO

Have you been physically hurt by someone in the last year? ☐ YES ☐ NO

Within the last year has someone forced you to have sexual activity? ☐ YES ☐ NO

If you have been diagnosed as having Diabetes, please answer.

When was your last Microalbumin lab test performed?
Date: ______________ ☐ Not Sure Where: ________________ ☐ Not Sure ☐ I've never had one

When was your last Hemoglobin A1C lab test performed?
Date: ______________ ☐ Not Sure Where: _________________ ☐ Not Sure ☐ I've never had one

When was your last eye exam?
Date: _______________ ☐ Not Sure Where: ________________ ☐ Not Sure ☐ I've never had one

When was your last foot exam?
Date: _______________ ☐ Not Sure Where: ________________ ☐ Not Sure ☐ I've never had one