

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: _____ / _____ / _____



Patient Name: _____ Date of Birth: _____

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.

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)		Carpal 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			

Please List Your Preferred Pharmacy: _____ Location: _____

LIFESTYLE / SOCIAL HISTORY

Do you smoke tobacco (circle one)? YES or NO

If yes, about how many/day? _____

Do you feel you need to change this habit? YES or NO

Do you drink alcohol (circle one)? YES or NO

If yes, please answer the following questions:

Approximately, how many drinks per week? 0-3 3 or more

If 3 or more drinks per week, how many per day? 0-2 2-5 5 or more

What is your favored drink type? Beer Wine Liquor Other: _____

Have you ever felt you should cut down on your drinking? YES or NO

Have people annoyed you by criticizing your drinking? YES or NO

Have you ever felt bad or guilty about your drinking? YES or NO

Have you ever taken a drink first thing in the morning to steady your nerves or get rid of a hangover? YES or NO

Do you use other substances such as marijuana or other drugs (circle one)? YES or NO

If yes, about how many times? Per week _____ Per day _____

Please list substance(s) used: _____

How many days in the last two weeks have you been bothered by the below symptoms?

Little Interest, Pleasure in Activities Not at all Several Half or More Nearly All

Feeling Down, Depressed, Hopeless Not at all Several Half or More Nearly All

Please continue on to the following questions, if you chose an option other than "not at all" from the questions above. If you have chosen "not at all" to both questions, you may skip to the next section.

How many days in the last two weeks have you been bothered by the below symptoms?

Trouble Falling or Staying Asleep Not at all Several Half or More Nearly All

Feeling Tired or Little Energy Not at all Several Half or More Nearly All

Difficulty Getting Along with Others Not at all Several Half or More Nearly All

Thoughts about Hurting Yourself Not at all Several Half or More Nearly All

Trouble Concentrating Not at all Several Half or More Nearly All

Poor Appetite or Overeating Not at all Several Half or More Nearly All

Feeling Bad about Yourself Not at all Several Half or More Nearly All

Name: _____ Date of Birth: _____ Today's Date: _____

DOMESTIC VIOLENCE SCREENING

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 let us know when your last testing was completed below.

Name of Test	Date Last Performed	Place Last Performed	If unknown, circle option:
Microalbumin			NOT SURE or NEVER
Hemoglobin A1C			NOT SURE or NEVER
Eye Exam			NOT SURE or NEVER
Foot Exam			NOT SURE or NEVER

IMMUNIZATIONS: Please check off any vaccinations you have had, please add the approximate date if known.

Vaccination:	Month /Year:	Vaccination:	Month /Year:
Flu Shot		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

FUTURE PLANNING

Do you have an advance directive? YES or NO

If yes, does PSMC have a copy of it? YES or NO

If no, please provide a copy to PSMC for our records.

If you do not have an advance directive, do you wish to receive further information? YES or NO