Patient Name:____ **Age**:_______ **DOB**:________________
First Middle Last

Address: ____
Street City State Zip

Home Phone:___________________________ **Cell Phone**: _______________________________

Social Security # :_______-_____-________ **E-Mail**: ____

Sex: (circle one) **M F** **Marital Status**: (circle one) Married Widow Single Divorced Separated

Employer: _________________________________

Race: Caucasian Asian Hawaiian Pacific African American American Indian Other____________________

Language: English Spanish French Creole Other_________________

Responsible Party (If other than patient):

Name:____ **Age**:_______ **DOB**:________________
First Middle Last

Address: ____
Street City State Zip

Home Phone:___________________________ **Cell Phone**: _______________________________

Social Security # :_______-_____-________ **Relationship:** ______________________________________

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co: ________________________________ Name of Policyholder: _________________________ DOB: __________________________ ID #: ___________________________ Group #: ________________________	Insurance Co: ________________________________ Name of Policyholder: _________________________ DOB: __________________________ ID #: ___________________________ Group #:__________________________

○ I authorize Schneck Primary Care to speak with the individual(s) listed below regarding my medical condition.	○ I authorize Schneck Primary Care to release any prescriptions, correspondence, or medication samples to the individual(s) listed below.	○ I only want medical information given to me personally.

Name: Relationship: Phone:	Name: Relationship: Phone:

Revised 7/2024

MEDICATIONS List all current prescriptions, over the counter medicines, vitamins, home remedies, herbs, etc.

Medication Name	Dose (mg/pill, units, etc)	Frequency (times/day)

ALLERGIES List all allergies to medications, dyes, other: ☐ None

Medication Name	Reaction

PAST MEDICAL HISTORY Circle conditions you currently have or have had in the past

Anxiety	Diabetes	Multiple Sclerosis
Anemia	Emphysema/COPD (Lung Disease)	Pneumonia
Asthma	Epilepsy/Seizures	Prostate Problems
Arthritis	Fibromyalgia	Stroke/TIA
Abnormal Pap Smear	Gout	Thyroid Problems
Bleeding Disorder	Headaches	Ulcers/Heartburn/Reflux
Bladder Infections	Heart Disease	Pneumonia
Blood Pressure (High)	Heart Irregularity (Too Fast, Slow)	Prostate Problems
Blood Pressure (Low)	Hepatitis	Stroke/TIA
Cancer	High Cholesterol	Other:
Type:________________________	Intestinal Problems	
Chronic Pain	Kidney Disease	
Depression	Liver Disease	

PAST SURGICAL HISTORY Circle surgeries you have had in the past

Appendectomy	Back/Joint Replacement	Heart	Hysterectomy
Gall Bladder	C-Section	Sinus	Tonsil & Adenoid
Prostate/Bladder	Other:		

HEALTH MAINTENANCE SCREENING TESTS Indicate date of last screening/exam

Eye Exam ______________ Colonoscopy ______________ Pap Smear ________________
Dental Exam____________ Mammogram _____________ Physical Exam ____________

SPECIALISTS: List any current or previous specialists; Include their name and city
____
____
____

HEALTH HABITS Indicate status of health habits listed below.

Alcohol Use : Never Occasionally Daily

Smoking Use: Never Former Smoker Trying to Quit Smoker PPD ________ # of Years _______

Illegal Drug Use: Never Former Drug Use Occasionally Daily

CURRENT HEALTH CONCERNS Please list any concerns below.

So that Schneck Primary Care can best serve my medical needs, I have completed this questionnaire as completely and honestly as possible. I understand that the Patient/Health Care Provider relationship is built on trust and honesty. By completing and signing this form, I acknowledge that any intentionally false information could seriously affect my health.

____ _________________________
Signature of Patient or Responsible Party **Date**

Revised 7/2024