**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: _____<br>Name of Policyholder: _____<br>DOB: _____<br>ID #: _____<br>Group #: _____ | Insurance Co: _____<br>Name of Policyholder: _____<br>DOB: _____<br>ID #: _____<br>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:<br><br>Relationship:<br><br>Phone: | Name:<br><br>Relationship:<br><br>Phone: |

**MEDICATIONS** List all current prescriptions, over the counter medicines, vitamins, home remedies, herbs, etc.: ☐ **None**

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

**PREFERRED PHARMACY**: _____

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

| Medication Name | Reaction |
|---|---|
| | |
| | |
| | |
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| | |

**PAST MEDICAL HISTORY** Circle conditions you currently have or have had in the past: ☐ **None**

| | | |
|---|---|---|
| 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 ☐ **None**

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

**FAMILY MEDICAL HISTORY** Circle family conditions (Mother/Father, Brother/Sister, Grandparent)

☐ **None**

| | | |
|---|---|---|
| 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 | |

**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. ☐ **None**

**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**