ACCESS
Primary Care Physicians, Inc.

Referred by: Name:_____ TODAY'S DATE:_____

# Patient Information Form (Please Print)

**Primary Care Physician:**

**Have you been a patient of Access Primary Care Physicians, Inc. in the past?** ☐ Yes ☐ No

## PATIENT

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

**Last** | **First** | **MI** | **Date of Birth** | **Age**

**Address** | **City** | **State** | **Zip**

**Sex:** ☐Male ☐Female

**Are you a student?** ☐ Yes ☐ No

**Street Address (if different from mailing)** | **City** | **State** | **Zip**

**Phone (Home)** | **Name of Employer** | **Employer's Phone #**

**Phone (Mobile)** | **Employer's Address**

Preferred Method of Contact? ☐Home Phone ☐Mobile Phone
May we send appointment and treatment reminders via text and voicemail? ☐Yes ☐No

**Email:**

**Spouse's Name** | **Date of Birth**

## ADDITIONAL INFORMATION

**Race:** ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific ☐Black ☐White ☐Hispanic ☐Other ☐Decline to Answer

**Ethnicity:** ☐Hispanic ☐Non-Hispanic | What Language do you prefer? ☐English ☐Spanish

**Name of your Pharmacy** | **Address**

**City** | **State** | **Zip** | **Phone #**

## RESPONSIBLE PARTY

☐ Self
☐ Spouse
☐ Guardian
☐ Other

**Last** | **First** | **MI** | **Phone Number:**

**Address**

**City** | **State** | **Zip**

## IN CASE OF EMERGENCY NOTIFY

**Name** | **Relation**

**Address** | **Phone #**

## INSURANCE INFORMATION

**Primary Insurance** | **Address**

**Policy Contract #** | **Group #** | **City** | **State** | **Zip**

**Name of Policy Holder** | **Date of Birth**

**Secondary Insurance** | **Address**

**Policy Contract #** | **Group #** | **City** | **State** | **Zip**

**Name of Policy Holder** | **Date of Birth**

ACCESS
Primary Care Physicians, Inc.

Date:_____

# PATIENT INFORMATION FORM

Patient's Name:_____ Guardian's Name (if under 18): _____

## ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

| Medication or Other (Environmental) | Reaction |
|---|---|
| | |
| | |
| | |

## FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

| Condition | Mother | Father | Maternal Grandparents | Paternal Grandparents | Brother | Brother | Sister | Sister | Additional Sibling(s) |
|---|---|---|---|---|---|---|---|---|---|
| Cancer | | | | | | | | | |
| Diabetes | | | | | | | | | |
| Heart Attack | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| High Cholesterol | | | | | | | | | |
| Stroke | | | | | | | | | |
| Other | | | | | | | | | |

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

| Relationship | Cause of death | Age at death | Relationship | Cause of death | Age at death |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## YOUR HEALTH HISTORY

(Check if you have had any of the following)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Abnormal Heart Rhythm | ☐ | Chronic Pain | ☐ | Heartburn/GERD | ☐ | Obesity |
| ☐ | Allergies (any) | ☐ | Chronic Kidney Disease | ☐ | Heart Murmur | ☐ | Osteoporosis |
| ☐ | Anemia | ☐ | Depression | ☐ | Hepatitis | ☐ | Peripheral Vascular Disease |
| ☐ | Anxiety/Stress | ☐ | Diabetes | ☐ | High Blood Pressure | ☐ | Seizures/Epilepsy |
| ☐ | Asthma | ☐ | Emphysema/COPD | ☐ | High Cholesterol | ☐ | Sleep Apnea |
| ☐ | Arthritis | ☐ | Gallbladder Disease | ☐ | HIV/AIDS | ☐ | Stomach Ulcers |
| ☐ | Atrial Fibrillation | ☐ | Gout | ☐ | Irritable Bowel Syndrome | ☐ | Stroke |
| ☐ | Colitis or Crohn's Disease | ☐ | Headaches/Migraines | ☐ | Kidney Failure | ☐ | Thyroid Disease |
| ☐ | Cancer | ☐ | Heart Attack/Failure | ☐ | Kidney Stones | | |

## PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

| Test | Date | Results | Physician |
|---|---|---|---|
| Colonoscopy | | | |
| Cholesterol Screening | | | |
| Cardiac Stress Test | | | |
| Bone Density | | | |
| Mammogram | | | |
| Breast Exam | | | |

| Vaccine Type | Date |
|---|---|
| Tetanus (Td) | |
| Pneumonia | |
| Hepatitis B | |
| Influenza (Flu) | |
| Shingles | |
| Other | |

## OB/GYN HISTORY

| | |
|---|---|
| Number of Pregnancies | |
| Number of full term babies | |
| Number of premature babies | |
| Number of abortions/miscarriages | |
| Number of living children | |

## ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO** **If yes, please describe**

NAME:_____ Date:_____

| PAST SURGICAL HISTORY | | | |
|---|---|---|---|
| **Date** | **Surgery** | **Date** | **Surgery** |
| | | | |
| | | | |
| | | | |

Please List Any Additional Medical Information:

_____

## HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke?_____How many packs per day? ____

Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week?_____How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where?

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

| Device | Yes/No | Device | Yes/No | Device | Yes/No |
|---|---|---|---|---|---|
| Cane | | Walker | | Bi-pap (sleep apnea) | |
| Electronic Scooter | | Wheelchair | | C-pap (sleep apnea) | |

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

| LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS | | | |
|---|---|---|---|
| **Name** | **Dose** | **Frequency** | **Ordering Provider** |
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| PHYSICIANS LIST (Please list any other physicians currently assisting in your care) | | | | | |
|---|---|---|---|---|---|
| **Specialty** | **Physician** | **Specialty** | **Physician** | **Specialty** | **Physician** |
| Allergy/Immunology | | Hematology | | Pain Management | |
| Cardiology | | Nephrology | | Podiatry | |
| Chiropractor | | Neurology | | Psychiatry/Mental Health | |
| Dental | | OB/GYN | | Pulmonary Medicine | |
| Dermatology | | Oncology | | Rheumatology | |
| Endocrinology | | Ophthalmologist | | Sleep Medicine | |
| Gastroenterology | | Optometrist | | Urology | |
| General Surgery | | Orthopedics | | Other Specialty | |

Do you have an advance directive/living will? **YES NO (circle one)**

If yes, please supply the office with a copy for your chart. If no, would you like one? **YES NO (circle one)**