



Referred by: Name: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

## Patient Information Form (Please Print)

	Primary Care Physician:	Have you been a patient of Secure Health Medical Group, Inc. in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b><u>PATIENT</u></b>  <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Last <span style="margin-left: 100px;">First</span> <span style="margin-left: 100px;">MI</span>		Date of Birth <span style="margin-left: 100px;">Age</span>		
	Address		City <span style="margin-left: 100px;">State</span> <span style="margin-left: 100px;">Zip</span>		
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Street Address (if different from mailing)		City <span style="margin-left: 100px;">State</span> <span style="margin-left: 100px;">Zip</span>		
	Phone (Home)		Name of Employer		Employer's Phone #
	Phone (Mobile)		Employer's Address		
	Preferred Method of Contact? <input type="checkbox"/> Home Phone <input type="checkbox"/> Mobile Phone May we send appointment and treatment reminders via text and voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Email:				
	Spouse's Name			Date of Birth	
	<b><u>ADDITIONAL INFORMATION</u></b>	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Decline to Answer			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		What Language do you prefer? <input type="checkbox"/> English <input type="checkbox"/> Spanish			
Name of your Pharmacy		Address			
City <span style="margin-left: 100px;">State</span> <span style="margin-left: 100px;">Zip</span>		Phone #			
<b><u>RESPONSIBLE PARTY</u></b>  <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other	Last <span style="margin-left: 100px;">First</span> <span style="margin-left: 100px;">MI</span>		Phone Number:		
	Address				
	City <span style="margin-left: 100px;">State</span> <span style="margin-left: 100px;">Zip</span>				
<b><u>IN CASE OF EMERGENCY NOTIFY</u></b>	Name			Relation	
	Address			Phone #	
<b><u>INSURANCE INFORMATION</u></b>	<b><u>Primary Insurance</u></b>		Address		
	Policy Contract #	Group #	City <span style="margin-left: 100px;">State</span> <span style="margin-left: 100px;">Zip</span>		
	Name of Policy Holder		Date of Birth		
	<b><u>Secondary Insurance</u></b>		Address		
	Policy Contract #	Group #	City <span style="margin-left: 100px;">State</span> <span style="margin-left: 100px;">Zip</span>		
	Name of Policy Holder		Date of Birth		

**PATIENT INFORMATION FORM**

Patient's Name: \_\_\_\_\_ Guardian's Name (if under 18): \_\_\_\_\_

<b>ALLERGIES TO MEDICATIONS or ENVIRONMENTAL</b>	
<b>Medication or Other (Environmental)</b>	<b>Reaction</b>

<b>FAMILY HISTORY</b>									
(Please check if your family has a history of any of these diseases)									
<b>Condition</b>	<b>Mother</b>	<b>Father</b>	<b>Maternal Grandparents</b>	<b>Paternal Grandparents</b>	<b>Brother</b>	<b>Brother</b>	<b>Sister</b>	<b>Sister</b>	<b>Additional Sibling(s)</b>
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:

<b>Relationship</b>	<b>Cause of death</b>	<b>Age at death</b>	<b>Relationship</b>	<b>Cause of death</b>	<b>Age at death</b>

<b>YOUR HEALTH HISTORY</b>					
(Check if you have had any of the following)					
<input type="checkbox"/> Abnormal Heart Rhythm	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Heartburn/GERD	<input type="checkbox"/> Obesity	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Allergies (any)	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anxiety/Stress	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Gout	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Colitis or Crohn's Disease	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>PREVENTATIVE HEALTH HISTORY</b>					
Check if you have had any of the following preventative health screening exams (month/year)					
<b>Test</b>	<b>Date</b>	<b>Results</b>	<b>Physician</b>	<b>Vaccine Type</b>	<b>Date</b>
Colonoscopy				Tetanus (Td)	
Cholesterol Screening				Pneumonia	
Cardiac Stress Test				Hepatitis B	
Bone Density				Influenza (Flu)	
Mammogram				Shingles	
Breast Exam				Other	

<b>OB/GYN HISTORY</b>	
Number of Pregnancies	
Number of full term babies	
Number of premature babies	
Number of abortions/miscarriages	
Number of living children	

<b>ACCIDENTS - TRAUMA:</b>
Have you ever had a severe accident? <b>YES NO</b> Do you have any metal pins/plates in your body? <b>YES NO</b> If yes, please describe

<b>PAST SURGICAL HISTORY</b>			
<u>Date</u>	<u>Surgery</u>	<u>Date</u>	<u>Surgery</u>

Please List Any Additional Medical Information:

\_\_\_\_\_

<b>HEALTH HABITS HISTORY</b>
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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?

<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>	<u>Device</u>	<u>Yes/No</u>
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.  
 \_\_\_\_\_

<b>LIST ALL PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS</b>			
<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Ordering Provider</u>

<b>PHYSICIANS LIST</b>					
(Please list any other physicians currently assisting in your care)					
<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>	<u>Specialty</u>	<u>Physician</u>
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)