SOUTH COUNTY INTERNAL MEDICINE WELCOMES YOU AS A PATIENT

Please fill out the following questionnaire to facilitate the input of information into our computer system. If you are unable to fill out this form for any reason, our staff will be happy to assist you.

Today's Date:

PATIENT INFORMATION

Mr.___ Mrs. ___ Ms. ___ Miss ___ Dr. ___ Fr. ___ Sr. ___ Br. ___ Other ___

Name: Social Security#:

Date of Birth: Gender:

Address: Marital Status:

Home Phone#: Work Phone#: Ext:

Cell: Email:

Employer:

IMPORTANT INFORMATION ABOUT YOU: (write same when applicable)

EMERGENCY CONTACT:

Name: Relationship:

Phone: Cell:

Other Demographics:

Race: (chose the most appropriate answer):

- American Indian or Alaska Native
- Black or African American
- More than one race
- Native Hawaiian
- Other Pacific Islander
- Refuse to report
- White

Ethnicity: (chose the most appropriate answer)

- Hispanic or Latino
- Not Hispanic or Latino
- Refuse to report

Primary Language:

ALLERGIES:

MEDICAL HISTORY

Check all that apply	You	Family History of this? (eg: Mother/Father/Aunt/Brother)	Describe if pertinent
Diabetes			
Thyroid disorder			
Asthma			
Bronchitis			
Emphysema (COPD)			
Kidney disorder			
Stroke			
Neurologic disorder			
Seizures			
Migraines			
Parkinson's Disease			
Alzheimer's or Dementia			
Cancer			
Anemia(blood loss/or bleeding)			
Depression			
Anxiety			
Behavioral Health Issues			
Heart Disease/Cardiac Disease			
High Blood Pressure (hypertension)			
STD			
Other			

Mother : Alive_____ Deceased_____ Age at death_____ Cause of death _____
Father: Alive_____ Deceased_____ Age at death_____ Cause of death _____

Have you had any major surgeries: (Specify type and year)

_____

_____

SOCIAL HISTORY:

Marital Status (circle): Single Married Divorced Widow

Your occupation: _____

Number of Children:_____ For women: Number of pregnancies _____

Do you currently smoke or use tobacco? Yes _____ No _____
If yes: How much do you smoke: Cigarettes_____ E-cigarettes_____ Cigars _____
If current smoker: Are you ready to set a quit date? Yes_____ No_____
Former smokers: Quit date_____ # of cigarettes/day_____ # of years_____

Alcohol intake: Number of drinks_____ per: day _____ week_____ other_____

Do you exercise? Yes _____ No _____

IMMUNIZATIONS: (vaccines) Year of Last Dose

Tetanus or Tdap _____

Hepatitis B _____

Hepatitis A _____

Pneumonia vaccine (PPSV 23 or PCV 13) _____

Influenza (Flu) _____

Shingles Vaccine _____

HPV (Gardasil) _____

FOR WOMEN:

When was your last menstrual period? _____

When was your last PAP smear? _____

When was your last mammogram? _____

Do you have a gynecologist, who? _____

FOR MEN:

When was your last prostate exam? _____

FOR MEN AND WOMEN OVER 50:

Have you ever had a sigmoidoscopy?_____ colonoscopy?_____ Date_____ Doctor_____

Reason for your visit today?

_____

_____

Other Doctors I would like to have reports sent to:

_____

_____

Referred by: _____

Signature: _____