Patient Information and Questionnaire

Last Name _____ **First Name** _____ **MI** _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

Preferred Contact Phone Number HOME # _____ **CELL #** _____

Email address: _____ **Birth Date** _____

Sex _____ **Social Security** _____ **Driver Lic. #** _____

Marital Status: (select one) ☐ **Single** / ☐ **Married** / ☐ **Divorced** / ☐ **Widow** **Student Status:** ☐ **Full Time** / ☐ **Part-time** / ☐ **Non-student**

Preferred Language: _____ **Ethnicity:** (select one) ☐ **HISPANIC or** ☐ **NON-HISPANIC**

Race: (select one): ☐ **American Indian / Alaskan Native;** ☐ **Asian;** ☐ **African American ;** ☐ **Caucasian;** ☐ **Pacific Islander;** ☐ **Other;** ☐ **Declined**

Primary Insurance: _____ **Insurance Phone Number:** _____

Subscriber/Policy ID #: _____ **Group ID #:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Patient Relationship to Policy Holder: _____

Secondary Insurance: _____ **Insurance Phone Number:** _____

Subscriber/Policy ID #: _____ **Group ID #:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Patient Relationship to Policy Holder: _____

Patient Employer: _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

Work Telephone # _____ **Ext: #** _____ **Fax #** _____

Referring Physician: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Reason for Visit: _____

Emergency Contact

Name: _____ **Relationship to Patient:** _____ **Phone Number:** _____

Guarantor/Responsible Party Information

Name: _____ **Relationship to Patient:** _____ **Phone Number:** _____

Street: _____ **City:** _____ **State:** _____ **Zip Code:** _____

I hereby agree that the information provided above is accurate and current to the best of my knowledge.

Patient/Responsible Party Signature: _____

Date: _____

Patient Name:_____ DOB:_____ Today's Date:_____

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Street:_____ City:_____ State:_____ Zip Code:_____

Allergies

Medication/Food	Reaction

Have you ever had a reaction to contrast dye or iodine? ☐ yes ☐ no ☐ unsure

Do you have a latex allergy? ☐ yes ☐ no ☐ unsure

Patient Name:_____ DOB:_____ Today's Date:_____

Medication List

Please list all prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment.

Medication	Strength (how many milligrams)	Dose (number of pills)	How many times a day

Past Medical History

Diabetes: Type	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Hypertension (high blood pressure)	☐ Yes	☐ No
Diabetic Foot Exam Date	☐ Yes	☐ No
Retinal Exam Date	☐ Yes	☐ No
Hypothyroid (underactive thyroid)	☐ Yes	☐ No
Hyperthyroid (overactive thyroid)	☐ Yes	☐ No
Thyroid Nodule	☐ Yes	☐ No
Thyroid Cancer	☐ Yes	☐ No
Coronary Artery Disease / Heart Blockage	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Osteoporosis / Osteopenia	☐ Yes	☐ No
Prostate Cancer	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No
Blood Clots / DVT	☐ Yes	☐ No
Other Cancer Type		
Pituitary Problem / Disease	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Chronic Renal Insufficiency	☐ Yes	☐ No
CVA / Stroke	☐ Yes	☐ No
Peptic Ulcer / GERD	☐ Yes	☐ No
Colonoscopy Date	☐ Yes	☐ No
Asthma / COPD	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Other Medical History:		

Social History

Never smoker	☐ Yes	☐ No
Current every day smoker	☐ Yes	☐ No
Current some day smoker	☐ Yes	☐ No
Former smoker	☐ Yes	☐ No
Alcohol use Quantity	☐ Yes	☐ No
Past drug use	☐ Yes	☐ No
Current drug user	☐ Yes	☐ No
Exercise:		
Occupation:		
With whom do you live:		

Family History

Diabetes If Yes, Relation:	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Thyroid Cancer Type	☐ Yes	☐ No
Heart Disease (CAD)	☐ Yes	☐ No
Hypertension (high blood pressure)	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Osteoporosis / Osteopenia	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No
Prostate Cancer	☐ Yes	☐ No
If Yes, Relation:		

Other Family History:

Surgical History

Cataract (eye) surgery	☐ Yes	☐ No
Tonsillectomy (tonsils removed)	☐ Yes	☐ No
Thyroidectomy (thyroid surgery)	☐ Yes	☐ No
Thyroid Biopsy	☐ Yes	☐ No
Breast Biopsy	☐ Yes	☐ No
Mastectomy / Lumpectomy	☐ Yes	☐ No
Coronary Artery Bypass (heart surgery)	☐ Yes	☐ No
PTCA Angioplasty / Stent	☐ Yes	☐ No
Aortic or Mitral Heart Valve Repair	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Appendectomy (appendix removed)	☐ Yes	☐ No
Cholecystectomy (gallbladder removed)	☐ Yes	☐ No
Hysterectomy (total/partial)	☐ Yes	☐ No
Caesarian Section	☐ Yes	☐ No
Tubal Ligation (“tubes tied”)	☐ Yes	☐ No
Urinary or bladder surgery	☐ Yes	☐ No
Prostate Surgery	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
Colectomy (colon removal)	☐ Yes	☐ No
Back surgery	☐ Yes	☐ No
Hip surgery	☐ Yes	☐ No
Knee surgery	☐ Yes	☐ No
Other Surgical History:		