Patient Information (Please present your photo Identification and insurance card with this paperwork)

Legal Name: First | Middle | Last | Suffix (Jr, Sr, II, III etc.)

Preferred Name/Nickname

Date of Birth Mon Day Year _____/_____/_____

Gender listed on Insurance/Driver's License /State Identification
□ Male □ Female

Social Security Number_____-_____-_____

Street Address | **Apt/Ste/Unit** | **City** | **State** | **Zip**

Mobile/Cell Phone ( )

Home Phone ( )

Email address

Best way to contact me/leave messages (check all that apply): □ Phone/voicemail □ E-mail/Patient Portal □ US mail

Preferred Pronoun: □ Asked but unknown □ He, Him, His □ She, Her, Hers □ They, Them, Theirs □ Ze, Hir □ Other □ Declined

How would you (patient) Describe your Gender Identity

□ Female
□ Male
□ Female to Male (FTM) Transgender Male
□ Male to Female (MTF) Transgender Female
□ Choose not to disclose
□ Other _____

Sexual Orientation

□ Lesbian or Gay
□ Heterosexual (straight)
□ Something else
□ Choose not to disclose
Other_____

Marital Status □ Single □ Partnered □ Married □ Divorced □ Separated □ Widowed □ Other □

Preferred Language: □ Burmese □ English □ French □ German □ Japanese □ Italian □ Spanish □ Other □ Guajarati □ Kanjobal □ Tigrinya □ Sudanese

Student Status: □ Full-time □ Part-time □ Not a Student

Responsible Person for Bill -If Self leave blank

Relationship: □ Self □ Parent □ Life Partner □ Spouse □ Other

Legal Name: First | Middle | Last | Suffix (Jr, Sr, II, III etc.)

Street Address | **Apt/Ste/Unit** | **City** | **State** | **Zip**

Social Security # _____-_____-_____

Date of Birth _____/_____/____

Relationship □ Self □ Parent □ Life Partner □ Spouse □ Other

Insurance Information

Primary Insurance Name: □ Medicare □ Medicaid □ Blue Cross Blue Shield □ Molina □ United Healthcare □ Other: _____

Name of Policy Holder: | **ID Number:** **Group Number:** | **Policy holder date of birth:** _____/_____/_____

Relationship: □ Self □ Parent □ Life Partner □ Spouse □ Other: _____

Secondary Insurance Name: □ Medicare □ Medicaid □ Blue Cross Blue Shield □ Molina □ United Healthcare □ Other: _____

Name of Policy Holder: | **ID Number:** **Group Number:** | **Policy holder date of birth:** _____/_____/_____

Relationship: □ Self □ Parent □ Life Partner □ Spouse □ Other: _____

Employer Information

Employer Name:

Employer Street Address: | **Apt/Ste/Unit** | **City** | **State** | **Zip**

Work Phone:		**Occupation:**				
Employment Status:	□ **Full Time**	□ **Part Time**	□ **Active Duty**	□ **Retired**	□ **Not Employed**	□ **Self Employed**
				Date:		

Emergency Contact/ Relations/Role

Legal Name: First	**Middle**	**Last**	**Suffix (Jr, Sr, II, III etc.)**

Street Address	**Apt/Ste/Unit**	**City**	**State**	**Zip**

Mobile/Cell Phone ( )	**Home Phone** ( )	**Relationship to Patient**

Housing and Worker Status

Homeless Status:	□ **Doubling**	□ **Transitional**	□ **Street**	□ **Shelter**	□ **Not Homeless**	□ **Permanent Supportive Housing**
				□ **Other**	□ **Unknown**	

Migrant Worker Status

□ **Migrant** □ **Not a Farm Worker** □ **Seasonal Worker**

Race:	□ Asian Indian	□ Korean	□ Other Pacific Islander	□ American Indian/Alaskan Native
	□ Chinese	□ Vietnamese	□ Guamanian or Chamorro	□ White
	□ Filipino	□ Other Asian	□ Samoan	□ More than one race
	□ Japanese	□ Native Hawaiian	□ Black / African American	□ Unreported/Choose not to disclose race
Ethnicity:	□ Cuban	□ Mexican, Mexican American Chicano/a		□ Not Hispanic, Latino/a or Spanish origin
	□ Puerto Rican	□ Other Hispanic, Latino/a, or Spanish origin		□ Unreported/Choose Not to Disclose Ethnicity

Veteran Status: □ Yes □ No

How did you hear about us? _____

Current Household Income: Weekly $_____ Monthly $_____ Annually $_____

How many people live in your household? _____

PHC receives funding to provide financial benefits to clients. By providing your proof of your income PHC can determine whether you are eligible for these benefits.

Proof of your income includes, but is not limited to, your last two to three pay stubs, last year's W-2 form, last year's tax return or paperwork approved by a PHC financial counselor.

By signing, I understand that based on my income, I may be eligible for the PHC sliding scale. However, I must provide proof of income to receive these benefits within 30 days of my first visit.

I understand that I will be charged the full fee for my visit if I do not bring in documentation of income within 30 days of my first visit.
I understand that I will never be refused services at PHC due to failure to pay.

Patient Signature

_____ Date_____

Promise Healthcare Representative Signature

_____Date_____

Who Can Have Your Health Information

Please Fill out this form. It will tell us which family members and friends have your permission to have your health information.

Minor Consent for Treatment

Minor's full name: _____ Date of Birth: _____

A physician, nurse practitioner or physician assistant, dentist, dental hygienist, nurse, and mental health counselor are available, based on schedules, to provide primary health care, dental care, psychosocial services, and nutritional consultations.

Available services may include, but are not limited to:

- Physical examinations, health assessments, and/or screening for health problems
- Diagnosis and treatment of acute illness and injury
- Diagnosis and management of chronic illness
- Health education and promotion: outreach health
- promotion/prevention workshops will be offered.
- Immunizations
- Wellness promotion including smoking cessation, nutrition, and/or weight management.
- Reproductive health care including gynecological examinations, STD education, testing, and treatment, HIV/AIDS education, counseling/testing, and contraceptive services.
- Laboratory tests including throat cultures, complete blood counts, mono spots, etc.
- Mental health counseling services
- Dental examination and treatment
- Referrals to other agencies for services not provided at the Urbana School Based Health Center (USBHC)

PARENTAL/GUARDIAN CONSENT

By signing below, I certify and affirm that:

The aforementioned child has my consent to receive services offered by Promise Healthcare by its providers. I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian, or minor who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care services. I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing Promise Healthcare to provide services to my child in his/her best interest.

I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parental permission is required for such services.

I understand that if my child is 12 or older and were to receive mental health/substance abuse services Promise Healthcare, he/she/they may receive up to eight therapy sessions without my consent. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

This consent shall be effective from the date of signature for one year unless I terminate it in writing or at such time that the minor turns eighteen (18) or otherwise becomes emancipated.

Parent/guardian printed full name: _____

Relationship to minor: _____

If/when I am not available, I authorize the following person(s) to accompany this child to their appointment(s) if applicable (please state full name(s) and relationship to child):

Parent/guardian signature: _____Date: _____

Patient signature (12 years or older): _____ Date: _____

HIPAA Authorization form

Who Can Have Your Health Information

Patient name:	Date of Birth:

ABOUT THIS FORM:

- Let those listed below have information about your medical care or payment.
- Informs those listed below or a disaster relief organization of your location, health, or death

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION

1. NAME:		Relationship to you:	
Phone #:	Street Address:		
City:		State:	Zip Code:
2. NAME:		Relationship to you:	
Phone #:	Street Address:		
City		State:	Zip Code:
3. NAME:		Relationship to you:	
Phone #:	Street Address:		
City		State:	Zip Code:

PLEASE SIGN HERE:

By signing below, I allow Promise Healthcare to talk about or release my health information with the people listed above.

Mark All You Approve:

- ☐ All Information
- ☐ Billing Information
- ☐ Appointment Information
- ☐ Lab Results
- ☐ Testing Results
- ☐ Treatment(s)
- ☐ Dental Services
- ☐ Other: _____

Patient/Parent/Guardian Signature:	**Today's Date**

Your permission expires in one year unless cancelled in writing

SENSITIVE MEDICAL INFORMATION TO BE RELEASED (Patient Initial and Date Required for Each Item):
I understand that the records requested above may contain sensitive medical information that requires my specific consent in order to be discussed. I specifically authorize Promise Healthcare to talk about or release my health information with the people listed above.

HIPAA Authorization form

☐ Mental/behavioral health	Initials:_____	Date:_____
☐ Alcohol/Drug abuse records	Initials:_____	Date:_____
☐ Genetics	Initials:_____	Date:_____
☐ Reproductive Care	Initials:_____	Date:_____
☐ HIV/AIDS/Sexually transmitted diseases	Initials:_____	Date:_____

Please note:
The following medical information of a Patient 12 – 17 years of age (Minor Patient) is restricted as follows:

Drug/alcohol use, Reproductive health, AIDS/HIV, or Birth Control/Sexually Transmitted Disease(s)/Sexual Assault, as well as any health information generated as a result of the Minor Patient's independent legally-authorized consent to treatment, requires the Minor Patient's signature to this discuss.

Mental health or developmental disabilities information is available after the Minor Patient's signature, provided the Minor Patient has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the Minor Patient's parent or guardian

Patient/Parent/Guardian Signature:	Today's Date

Your permission expires in one year unless cancelled in writing

Please Fill out this form. It will tell us which family members and friends have your permission to have your health information.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice applies to all Promise Healthcare locations.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We may ask you to make the request in writing.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

• You can ask us not to use or share certain health information for treatment, payment, or our operations.

• We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out- of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

• We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

• You can complain if you feel we have violated your rights by contacting us using the information on the last page of this notice.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/.

• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care.

• Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

• Marketing purposes

• Sale of your information

• Most sharing of mental health notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you.

• We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

• We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

• We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

The examples used in this Notice of Privacy Practices are illustrations only and not meant to be a complete list.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues.

• We can share health information about you for certain situations such as:

• Preventing disease

• Helping with product recalls

• Reporting adverse reactions to medications

• Reporting suspected abuse, neglect, or domestic violence

• Preventing or reducing a serious threat to anyone's health or safety

Do research.

• We can use or share your information for health research.

Comply with the law.

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests.

• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.

• We can use or share health information about you:

• For workers' compensation claims

• For law enforcement purposes or with a law enforcement official

• With health oversight agencies for activities authorized by law

• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions.

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Federal law privacy protections and state law privacy protections

HIPAA generally does not preempt or override other laws that give people greater privacy protections. If any applicable state or federal law requires us to provide you with more privacy protections, then we must follow that law in addition to HIPAA.

Some types of health information may have additional protection under federal or state law. For example, some genetic test results, mental health records, HIV / AIDS test results, educational records, and federally assisted alcohol and substance abuse treatment programs are subject to special restrictions on our use and disclosure under various laws.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

If you have any questions or would like further information about this Notice of Privacy Practices, please contact Promise Healthcare's Privacy Officer at 217-356-1558

Notice of Privacy Acknowledgement Form

By signing below, I acknowledge that I received and read the Notice of Privacy Practices.

Patient name	
Patient Signature	
Date:	

Patient Bill of Rights

Promise Healthcare works with you to exceed your expectations. We respect your rights to healthcare access, equity, and safety, and your privacy is our priority. Your rights, your responsibilities, and our pledges to you are listed below.

You have the right to:

- Receive respectful care regardless of your sex, age, race, religion, color, national origin, sexual orientation, or any other personal characteristics, including your primary source of payment.
- Be treated with consideration for your emotional, spiritual, and cultural needs.
- Be fully informed of available services at Promise Healthcare, including after-hours and emergency care and fees for all services.
- Expect reasonable continuity of care and have a provider who manages your care.
- Request a second opinion when you believe it is necessary.
- Know the names and positions of people involved in your care by official name tag or personal introduction.
- Have a reasonable choice of providers and information about your options. You can change providers if you are dissatisfied with your care using our procedure for changing providers. Please ask the front desk for help.
- Seek help, such as a wheelchair or interpreter, to obtain care easier.
- Receive the information about your health in a way that you can understand, take part in decisions about your care, and give your informed consent before any procedure is performed as per Illinois law.
- Be made aware of any unanticipated outcomes.
- Fully take part in the decision-making process about your care. You may have parents, guardians, family members, civil union partners, or other individuals that you choose to be involved.
- Refuse a recommended treatment, to the extent allowed by law, and be informed of the risks associated with and potential consequences of refusing to be treated.
- Expect that your health record will be kept confidential. For more information about your right to privacy, please review your HIPAA and Notice of Privacy statements.
- Ask and receive an explanation of any charges made by Promise Healthcare, even if they are covered by insurance.
- Complete an advance directive for end-of-life care. Please let your care team know if you are interested in learning more about advance directives.
- Express any complaints or concerns through our patient grievance/comments form.

As part of our contract with you, we pledge to:

- Provide you with ethical treatment by caring and qualified healthcare providers.
- Provide services that are available to you as you need them.
- Provide emergency coverage and provider availability on call, 24 hours a day, 7 days a week by calling our office number. When the office is closed, the provider may consult with you by phone.
- Always deal with you honestly and openly.

- Provide you with financial help based on a sliding-fee scale. This is dependent upon your income.
- Provide you with a confidential and detailed explanation of your bill of services.
- Participate in measures to always ensure patient safety.

You have a responsibility to:

- Arrive on time for scheduled appointments and tell us if you are going to be late. If you are late, we cannot guarantee your appointment. Call us at least 24 hours in advance if you need to cancel or reschedule.
- Provide us with at least 48 hours' notice when you or a family member needs medications or a prescription.
- Follow all rules and regulations posted within Promise Healthcare.
- Speak and behave respectfully to Promise Healthcare staff and other patients.
- Respect the privacy and confidentiality of other patients.
- Turn off cell phones in clinical areas.
- Provide us with all needed information so we can keep an accurate file for you. This includes reporting any changes to your address, telephone number, status of advance directives, and if necessary, financial status.
- Pay your bills at the time of service including co-payments and deductibles or arrange a payment plan if needed.
- Provide honest and complete information about your health concerns, past health medical history, medications, and unexpected changes in your health so that we can provide you with the highest level of care.
- Provide us with medical records upon request.
- k questions if you do not understand any information or instructions, we give you.
- Develop a treatment plan with your care team and follow it to the best of your ability. Be honest about what you have been able to do (or not do) when seen in follow-up. If you are unable to follow a treatment plan, we will do our best to help you find out why to change the plan or correct the problem if possible.
- Supervise children that are in your care.
- **Please note:** Making harassing, offensive, or intimidating statements or threats of violence could result in your removal from Promise Healthcare. If you are removed from one of our offices, you are considered removed from all Promise sites.

Patient Health History

This questionnaire is used to collect information about your current health history. In addition to providing your health care team with important clinical information, this questionnaire also helps us meet special requirements established by Medicare and other health insurers.

Patient Information:

Name: _____ Date of Birth: _____/_____/____ Gender at Birth: □Male □Female

What is your primary language? _____

Allergies:
Have you had hives, skin rash, breathing problems or other allergic reactions to medications? □Yes □No If yes, please list below:

Name of medicine:	Describe allergic reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side effects? □Yes □No

If yes, please specify: _____

Have you had allergic reaction to: Iodine or x-ray contrast dye? □Yes □No Latex or rubber (gloves, condoms, balloons)? □Yes □No

Shellfish? □Yes □No Bee or wasp stings? □Yes □No Adhesive tape? □Yes □No Other allergies (specify): _____

List any food allergies: □None
_____

Height: ____ Weight: ____ Recent weight change? □No □Yes Gain of ____ lbs. Loss of ___ lbs

If Female, are you Pregnant? □Yes □No Date of last Flu shot: _____

Past Medical history:

Check if you have or have had any of the following:

□ Acid Reflux
□ Alcohol Addiction
□ Anemia
□ Angina
□ Anxiety
□ Arthritis
□Asthma
□ Atrial fibrillation
□ Auto Immune Disorder
□ Bisphosphonate Treatment
□ Blood clots
□ Benign prostatic hypertrophy
□ Cerebrovascular accident
□ COPD
□ Cancer or Tumor
□Coronary artery disease
□ Chron's disease
□ Depression
□Diabetes
□ Eating Disorder
□ Fainting Spells
□ Gallbladder disease
□ GERD
□ Glaucoma
□ HIV Positive/AIDS
□ Hepatitis C
□Heart Disease/Surgery
□ Heart Murmur
□ Hepatitis A
□Hepatitis B
□ Hepatitis C
□ Irritable bowel disease
□ Joint Replacement
□ Hyperlipidemia
□ Hypertension/High Blood Pressure
□Kidney Problems
□ Learning Disability
□ Liver disease
□ Low Blood Pressure
□ Lung Disease
□Lupus
□ Migraine headaches
□ Myocardial infection
□ Neurological Disorder
□ Organ Transplant
□ Osteoarthritis
□ Osteoporosis
□Pacemaker
□ Psychiatric Care
□ Peptic ulcer disease
□ Radiation Therapy
□ Rheumatic Fever
□ Renal disease
□ Seizure/Epilepsy disorder
□ Sexually Transmitted Illness (STI, STD)
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Other (Specify)_____

Name: _____ Date of Birth: _____/_____/____

Past surgical history:

Please check all that applies:

	Year		Year		Year
□ Angioplasty	_____	□ Colectomy	_____	□Pacemaker	_____
□ Angio w/ stent	_____	□Colostomy	_____	□Prostate biopsy	_____
□ Appendectomy	_____	□ Gastric bypass	_____	□ Small bowel resection	_____
□ Arthroscopy	_____	□ Hernia repair	_____	□ Thyroidectomy	_____
□ Back surgery	_____	□ Hip replacement	_____	□ Tonsillectomy	_____
□ CABG	_____	□ Knee replacement	_____	□ TURP	_____
□ Carpal tunnel	_____	□ LASIK	_____	□ Vasectomy	_____
□Cataract extraction	_____	□Liver biopsy	_____	□ Other (specify): _____	
□ Cholecystectomy	_____	□ ORIF	_____		

Hospitalizations: Please list past major hospitalizations:

Have you been Hospitalized in the Past 10 years? □Yes □No

Year	Place	Illness/Injury	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dental History

What was the date of your last dental visit? _____

Previous Dentist's name: _____

Please list any concerns you have about dental treatments:

_____

_____

Has your Physician told you to pre-medicate prior to dental appointments due to a medical condition? □Yes □No

Alcohol:

Do you drink alcohol? □Yes □No What type of alcohol? _____ How much do you drink in a usual week? _____ When did you drink last? _____ If you have quit drinking, when did you quit? _____How many times in the past year have you had 4+ drinks in a day if you're a woman, 5+ drinks in a day if you're a man?

Marijuana Use:

In the past 12 months have you used marijuana? □Yes □No How often do you use marijuana? _____

Substance Use:

In the past 12 months, have you used any illegal substance for example cocaine, crack, heroin, methamphetamine (crystal Meth), hallucinogens, ecstasy/MMDA? ☐ Yes ☐ No How often have you used cocaine, crack, heroin, methamphetamine (crystal Meth), hallucinogens, ecstasy/MMDA? _____

In the past 12 months have you misused prescription drugs? ☐ Yes ☐ No How often have you misused prescription drugs? _____

Name: _____ Date of Birth: _____/_____/____

Family History

Year of birth		Major Illness (if applicable, cause of death)	Living/Deceased	If deceased, what age?
Father				
_____		_____	□Yes □No	_____
Mother				
_____		_____	□Yes □No	_____
Siblings	Gender			
_____	□M □F	_____	□Yes □No	_____
_____	□M □F	_____	□Yes □No	_____
Children	Gender			
_____	□M □F	_____	□Yes □No	_____
_____	□M □F	_____	□Yes □No	_____

Family History:

Please check if any family members have had any of the following and who in the family had it. (Example: Al

□Anemia
□Angina
□Anxiety
□Arthritis
□Asthma
□Atrial fibrillation
□Benign prostatic hypertrophy
□Blood clots
□Cancer
□Cerebrovascular accident
□COPD
□Coronary artery disease
□Chron's disease
□Depression
□Diabetes
□Gallbladder disease
□GERD
□HIV
□Hepatitis C
□Hyperlipidemia
□Hypertension
□Irritable bowel disease
□Liver disease
□Migraine headaches
□Myocardial infection
□Osteoarthritis
□Osteoporosis
□Peptic ulcer disease
□Renal disease
□Seizure disorder
□ Thyroid disease
□Other (Specify)_____

Please list below all the medication you are currently taking and who prescribed it:

Medications:	Prescribing Doctor:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____