Hollen Family Medicine

Patient Demographic Information Intake Form

Patient Name: _____ Date of Birth:_____

Social Security#: _____-_____-_____ Driver's License#: _____

Ethnicity: (Circle One) Hispanic or Non-Hispanic

Race: (Circle all that apply) American Indian or Alaska Native Asian or Pacific Islander Hispanic

Asian, Not Hispanic Black or African American Multiracial, Two or more races Native Hawaiian or Other Pacific

Islander White/Caucasian, Not Hispanic Other: _____

Are you a Veteran: (Circle One) Yes or No

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____

Email Address: _____

Employer: _____ Phone: _____

Employment Status: (Circle One) Full-Time Part-Time Unemployed Self-Employed

Marital Status: (Circle One) Minor Single Married Divorced Widowed

Emergency Contact: _____ Phone: _____

If patient is a Minor:

Mother's Name: _____ Phone: _____

Mother's Date of Birth: _____

Father's Name: _____ Phones: _____

Father's Date of Birth: _____

Patient Health History Intake Form

MEDICATIONS: Please list ALL medications you are currently taking (Including vitamins and over the counter medications)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PREFERRED PHARMACY:

Name: _____

Location: _____ Phone: _____

ALLERGIES:

Are you allergic to any of the following medications or materials? (Circle all that apply)

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Metal ☐ Latex ☐ Iodine

☐ Local Anesthetics ☐ Barbiturates ☐ Acrylic ☐ Other: _____

IMMUNIZATION HISTORY: Any childhood illness (Check all that apply)

☐ Chicken Pox ☐ Rheumatic Fever ☐ Measles ☐ Mumps ☐ Scarlet Fever ☐ Rubella

☐ Other: _____

Immunizations and most recent completion date:

☐ Chickenpox	Date:	☐ Meningococcus	Date:
☐ MMR (Measles, Mumps, Rubella)	Date:	☐ Gardasil/HPV	Date:
☐ Hepatitis A	Date:	☐ Hepatitis B	Date:
☐ Tdap (Tetanus and pertussis)	Date:	☐ Pneumonia	Date:
☐ Flu Shot Date:	Date:	☐ Tetanus	Date:
☐ Zostavax (Shingles)	Date:		

PERTINENT MEDICAL HISTORY:

Are you currently under another physician's care (specialist or clinic)?	Yes ☐ No ☐ If yes, please explain: _____
Have you ever been hospitalized overnight or had any major surgery?	Yes ☐ No ☐ If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes ☐ No ☐ If yes, please explain: _____
Are you on a special diet?	Yes ☐ No ☐ If yes, please explain: _____

PAST MEDICAL HISTORY (Please check all that apply)

☐ Anxiety Disorder	☐ Diverticulitis	☐ Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐ Gout	☐ Leg/Foot Ulcers
☐ Bleeding Disorder	☐ Has Pacemaker	☐ Liver Disease
☐ Blood Clots	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux Disease	☐ Pulmonary Embolism
☐ Claustrophobic	☐ HIV or AIDS	☐ Reflux or Ulcers
☐ Diabetes – Insulin	☐ Diabetes – Non-Insulin	☐ Strokes
☐ High Blood Pressure	☐ High Cholesterol	☐ Tuberculosis
☐ Dialysis	☐ Overactive Thyroid	☐ Other

SOCIAL HISTORY

EDUCATION: ☐ < 8th grade ☐ High School ☐ 2 Yr College ☐ 4 Yr College ☐ Post Graduate	MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner	EXERCISE: ☐ No exercise ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise
CAFFEINE: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy # cups/cans per day? ____	ALCOHOL: Drink Alcohol? Yes ☐ No ☐ # Drinks/week? ____ ☐ < 3 times/week ☐ Occasionally ☐ > 3 times/week	DRUGS: Do you use Marijuana? Yes ☐ No ☐ What form? _____ How often? _____ Do you currently use recreational or street drugs? Yes ☐ No ☐ If yes, please list:

TOBACCO:

Do you use Tobacco?
Yes □ No □

If not now, did you ever use tobacco?
Yes □ No □

How often? _____ # Years Used _____ Or year quit _____

□ Cigarettes ____ pks/day □ Chew ____ /day □ Cigars ____/day

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Obstetric History:		Check below if any of these apply to you:	
Number of Pregnancies:	□ _____	□ Bleeding between periods □ Heavy Periods	
Number of Miscarriages:	□ _____	□ Extreme Menstrual Pain □ Vaginal itching, burning, or discharge	
Number of Cesarean sections:	□ _____	□ Waking in the night to go to the bathroom □ Hot flashes	
Number of Births:	□ _____	□ Breast lump or nipple □ Painful intercourse	
Number of Abortions:	□ _____		
Are you pregnant/trying to get pregnant?	□ Yes □ No	Are you currently nursing?	□ Yes □ No
First Menstrual Period	Date/Age:	Last Period/Age of Menopause:	Date/Age:
Last PAP Smear	Date: □ Abnormal □ Normal	Last Mammogram	Date: □ Abnormal □ Normal
Sexually Active?	□ Yes □ No	Do you use condoms?	□ Yes □ No
Current sexual partner is:	□ Female □ Male	Are you taking Oral Contraceptives?	□ Yes □ No
Interested in being screened for STDs:	□ Yes □ No	Other Birth control method used:	

ADDITIONAL HEALTH FACTS

Please add other information about your health that you would like your provider to know here:
