Family Medicine Center Registration Questionnaire

Patient Name:_____ Date of Birth:_____

Billing Address: _____City/State:_____Zip:_____

Alternate Address:_____

SSN: _____ Email Address: _____

Phone #: _____ Cell#: _____

Work #: _____ EXT:_____ Best Contact number? _____

Regarding the office staff or physician leaving information or confirming appointments on my answering machine, voicemail, or with my answering service?

- ☐ **YES**, I give permission for medical information (ex: Normal test results) to be left on my answering systems.
- ☐ **NO**, I do not want messages or medical information left on my answering systems. A message will be left requesting you call the office at your convenience.

Is there anyone you would like us to speak to or leave a message with other than yourself? :

Name: _____

Emergency Contact:_____Phone #_____ Relation_____

Marital Status (Circle One) **S** **M** **D** **W**

Laboratory: **LabCorp** **Quest** **Meridian** **Other**: _____

Local Pharmacy: _____ Location:_____

Mail Away: _____

Do you have an advanced directive/Living Will? (Circle One) **YES** **NO**
*If yes please provide the office with a copy

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I have been offered a copy this provider's NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under Federal and State Law. I understand that the contents of the notice.
Signature:_____ Date:_____

Missed Appointment Policy: Effective March 1, 2008 Family Medicine Center will be charging all patients $30.00 for missed appointments, We must receive notice of cancellation 4 hours prior to the scheduled appointment time. I have read this policy and understand the above written policy.

Signature:_____ Date:_____

Insurance Information

Primary Insurance:_____ ID#:_____

Subscriber: _____ Subscriber DOB: _____

Subscriber SSN: _____ Referrals Required? : **YES** **NO**

Secondary Insurance:_____ ID#:_____

Subscriber: _____ Subscriber DOB: _____

Subscriber SSN: _____ Referrals Required? : **YES** **NO**

INSURANCE AUTHORIZATION AND ASSIGNMENT: I authorize Family Medicine Center to furnish information to my insurance carrier concerning my illness and treatment. I also authorize payment of benefits be made either to me or on my behalf to Family Medicine Center for any services rendered to myself or my dependents. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE COMPANY.**

INSURANCE AUTHORIZATION: I request that payment of authorized insurance benefits be made either to me or on my behalf Family Medicine Center for any services furnished me by this physician/supplier. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine the benefits for related services. I understand my signature requests payment be made for services. If "other insurance" is indicated in Item #9 (of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature_____ Date_____

This Information is Voluntary:

Please Circle you race: American Indian/Native Alaskan Native Hawaiian/Pacific Islander

Asian African American/Black White Hispanic Other Refuse to report

Ethnicity (Please Circle): Hispanic/Latino Not Hispanic or Latino Refuse to report

Language (Please Circle): English Spanish Sign Language Other:_____

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems or allergies that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				

	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	