SoutheastHEALTH

PATIENT INFORMATION FORM

Patient Name: _____

Date of Birth: (M/D/Y) _____ **Birth Sex:** ☐ Male ☐ Female **SSN:** (patient) _____

Previous and/or Maiden Name: _____

Parent/Legal Guardian Name: (if patient is a minor) _____ **SSN :**(Parent/guardian) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____ **Marital Status:** ☐ Single ☐ Married

Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ Caucasian/White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Hispanic/ Latino ☐ Other: _____

EMPLOYMENT AND INSURANCE

Patient or Parent's Employer: _____ **Occupation:** _____

Primary Insurance Company: _____
Policy Holder's Name: _____ **Date of Birth:** _____
Policy Holder's Employer: _____ **Occupation:** _____
Relationship to Patient: _____ **SSN:** _____

Secondary Insurance Company: _____
Policy Holder's Name: _____ **Date of Birth:** _____
Policy Holder's Employer: _____ **Occupation:** _____
Relationship to Patient: _____ **SSN:** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____
Phone Number: _____ **Date of Birth:** _____

Name: _____ **Relationship:** _____
Phone Number: _____ **Date of Birth:** _____

Power of Attorney: _____

Do you have an Advanced Directive? (End of Life Care) ☐ Yes ☐ No

I consent for staff to leave a voice mail pertaining to your health information. ☐ Yes ☐ No

_____ _____

Signature of Patient or Guardian Date

Legal Name: _____ **Preferred name** (*if different*)**:**_____ **DOB:**_____ **Date:** _____

Sex: ☐ Male ☐ Female **Identifies as:** ☐ Male ☐ Female ☐ Other**:** _____

Preferred Pharmacy: ☐ Broadway Prescription Shop ☐ CVS ☐ CVS in Target ☐ Schnucks

☐ WM Super Center Cape ☐ WM Neighborhood Market (Cape) ☐ Walgreens ☐ **Other:** _____

Medications (Prescription and Over the counter):

☐ **None**

Name	Dose	Frequency

Allergies (including food and medication):

☐ **None**

Name	**Reaction**

Females only:

Age at first menstrual cycle	
First day of last menstrual cycle	
Date of last pap smear (if applicable)	
Have you ever been pregnant?	☐ **Yes or** ☐ **No If so, how many?**
If circled yes to pregnancy, how many are living?	

Past medical history (Check all that applies, if not listed please write in next to other**)**

☐ **None**

☐	ADHD	☐	Diabetes: 1 or 2	☐	Seizure disorder
☐	Allergies, environmental	☐	GERD	☐	Stroke
☐	Allergies, seasonal	☐	Headache, Migraine	☐	Thyroid Disease
☐	Anemia, if so type:	☐	Heart disease	☐	Schizophrenia
☐	Anxiety	☐	Heart valve disorder	☐	Post-traumatic Stress Disorder
☐	Arthritis	☐	Hepatitis		Other:
☐	Asthma	☐	High Cholesterol	☐	
☐	Bipolar Disorder: I or II	☐	High Blood Pressure	☐	
☐	Cancer, if so type:	☐	Inflammatory Bowel Disease	☐	
☐	Cardiac arrhythmia	☐	Irritable Bowel Syndrome	☐	
☐	Depression	☐	Osteoporosis	☐	

Past Surgical History (Check all that applies and when it was performed):

☐ **None**

	Surgery	Date		Surgery	Date
☐	Appendectomy		☐	Knee replacement	
☐	Arthroscopy		☐	Mastectomy	
☐	Back Surgery		☐	Thyroidectomy	
☐	Bilateral Tubal Ligation		☐	Tonsillectomy	
☐	Breast Augmentation		☐	Other:	
☐	Cardiac Pacemaker		☐		
☐	Carpal Tunnel Release		☐		
☐	Cholecystectomy (gallbladder removal)		☐		
☐	Colostomy		☐		
☐	Dilation and curettage		☐		
☐	Hip replacement		☐		

Family History (Check all that applies, please specify family member affected)

(If extended family specify if maternal or paternal)

☐ **None**

		Person			Person
☐	ADHD		☐	Hearing disorder	
☐	Alcoholism		☐	High Blood Pressure	
☐	Allergies		☐	Inflammatory Bowel Disease	
☐	Alzheimer's Disease		☐	Irritable Bowel Syndrome	
☐	Arthritis		☐	Mental Illness	
☐	Asthma		☐	Migraine	
☐	Blood Disorder		☐	Obesity	
☐	Cancer, if so type:		☐	Osteoporosis	
☐	Cardiovascular disease		☐	Peripheral Vascular Disease	
☐	Coronary Artery Disease		☐	Renal Disease	
☐	Depression		☐	Seizure Disorder	
☐	Diabetes: Type 1 or 2		☐	Stroke	
☐	Eczema		☐	Thyroid Disorder	
☐	High Cholesterol		☐	Other:	
☐	Genetic Disease		☐		

Social History:

Preferred Language: _____ Native Language (if different from preferred): _____

Country of Birth: _____ Marital Status: _____

Who is your support network? _____

Who may we release your information to?

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Tobacco Use (Check boxes accordingly):

☐ No/Never smoked ☐ Yes ☐ Former Smoker: Age Quit; _____

	Tobacco type:	Check if use daily	How much/often per day?	Years used	Age started
	Cigarettes	☐			
	Cigars	☐			
	Chew	☐			
	Smokeless	☐			
	E-Cigarette	☐			
	Other:	☐			

Alcohol Use:

Do you drink alcohol: ☐ Yes ☐ No ☐ If so what kind: _____

How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Socially ☐ Yearly

How much: _____ When was your last drink: _____

Substance Abuse:

Have you or do you currently use illegal drugs? ☐ Yes or ☐ No

If so, please specify type: _____

Sexual History:

Are you sexually active (oral, anal, or vaginal): ☐ Yes or ☐ No

If so, do you have sex with males, females or both: _____

Protected or Unprotected: _____