PATIENT INFORMATION FORM

Campus Clinic

SO#:_____

Patient Name (first, middle initial, last)**:** _____
Date of Birth: (M/D/Y) _____ **Birth Sex:** ◯ Male ◯ Female
SSN: (if applicable) _____
Previous and/or Maiden Name: _____
Parent/Legal Guardian Name: (if patient is under 18): _____
Parent SSN (if known): _____
Local Address/Dorm: _____ **Room #:** _____
City: _____ **State:** _____ **Zip:** _____
Local Cell Phone: _____ **SEMO 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 (if known): _____

Secondary Insurance Company: _____
Policy Holder's Name: _____ Date of Birth: _____
Policy Holder's Employer: _____ Occupation: _____
Relationship to Patient: _____ SSN (if known): _____

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

Full Legal Name: _____ **Preferred name (if different):** _____

DOB:_____ **Date:**_____ **Sex:** ◯Male ◯Female **Identifies as:**◯Male◯Female◯Other: _____ **Preferred Pronouns:** _____

Preferred Pharmacy (CIRCLE ONE): ◯Mercy Pharmacy Broadway **(Within Walking Distance)**

◯John's Pharmacy **(Delivers for FREE)** ◯CVS◯CVS in Target ◯CVS in Schnucks ◯ WM Supercenter ◯WM Neighborhood Market◯Walgreens ◯Medicenter ◯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 applies)	
Have you ever been pregnant?	◯Yes ◯No IF yes how many times?: _____
If circled yes to pregnancy, how many are living?	

Past Medical History (Check all that applies, if not listed write in next to other):

☐ **NONE**

☐	ADHD	☐	Migraine	☐	Eczema
☐	Allergies	☐	High cholesterol	☐	Other:
☐	Anemia	☐	High blood pressure		
☐	Anxiety	☐	Herpes (mouth or genital)		
☐	Asthma	☐	Crohns or Ulcerative Colitis		
☐	Bipolar Disorder: 1 or 2	☐	Irritable Bowel Syndrome		
☐	Cardiac arrythmia	☐	Seizure Disorder		
☐	Depression	☐	Thyroid Disorder		
☐	Diabetes: 1 or 2	☐	Schizophrenia		
☐	Heartburn	☐	PTSD		

Past Surgical History (Check ALL that applies and mark the year it was performed):

☐ **NONE**

☐	Appendectomy	☐	Dilation and Curettage
☐	Arthroscopy	☐	Thyroidectomy
☐	Back surgery	☐	Tonsillectomy
☐	Breast augmentation	☐	Other:
☐	Cholecystectomy (gallbladder removal)		

Family History (Check ALL that applies and please specify which family member is affected):

☐ **NONE**

☐	ADHD	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Alcoholism	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Asthma	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Blood Clotting Disorder	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Cancer, if so what type: _____	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Depression	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Diabetes: 1 or 2	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Eczema	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Heart Attack	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	High Cholesterol	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	High Blood Pressure	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Inflammatory Bowel Disease – Crohn's/Ulcerative Colitis	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Migraine	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Obesity	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Stroke	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Thyroid Disease	☐Father ☐Mother ☐Grandfather ☐Grandmother
☐	Other:	☐Father ☐Mother ☐Grandfather ☐Grandmother
		☐Father ☐Mother ☐Grandfather ☐Grandmother
		☐Father ☐Mother ☐Grandfather ☐Grandmother

Social History:

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

Country of Birth: _____ Marital Status: _____

Who may we release your information?

Name:	Relationship to you:

Tobacco Use (Check boxes accordingly):

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

	Tobacco Type:	Check if use daily:	How much/often per day?:	Years used:	Age started:
☐	Cigarettes	☐			
☐	Cigars	☐			
☐	Chew	☐			
☐	E-cigarettes Yes or No	☐			
	If e-cigarettes use, what brand: _____				

Alcohol Use:

Do you drink alcohol: ◯ Yes ◯ No if YES what kind: _____

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

How much: _____ When was your last drink: _____

Substance Abuse (including Marijuana):

Do you currently use **marijuana**, **recreational**, or **illegal** drugs? ◯ Yes ◯ No

If YES, please specify type of drug: _____ How often: _____

Have you ever used an **illegal** drug? ◯ Yes ◯ No

If so, please specify type: _____

Sexual History:

Have you ever been sexually active before (ORAL, ANAL, or VAGINAL)? ◯ Yes ◯ No

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

Condom use, **unprotected sex** or **both**? _____