Suburban Medical Group

Medical History *Date:* _____ /_____ /_____

Name _____ Age _____ Birth Date ____/____/____
SSN _____ Sex: M F
Email _____ Home Phone _____
Address _____ Cell Phone _____
_____ Work Phone _____
_____ Emergency Contact _____
Occupation _____ Phone _____
Preferred Phone: □ Home □ Cell □ Work May we leave a detailed message? □ Yes □ No
Race □ American Indian □ Asian □ African American □ Caucasian □ Decline to specify
Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated
If married, spouse's name _____
Children's names and ages _____
**How did you hear about our office? _____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction):

_____ _____
_____ _____

Primary Insurance Information

Insurance Name _____

Subscriber's Name (if not self) _____ DOB_____

Relationship of subscriber _____ Spouse _____Parent

Secondary Insurance Information

Name of Insurance _____

Pharmacy Information

Local Pharmacy_____ Phone_____Zip Code_____

Mail Order_____ Phone_____

Please List and Supply the Year of:

Operations: _____ _____
_____ _____
Hospitalizations other than for surgery: _____
_____ _____

Immunization history – have you had: Pneumonia? ☐ No ☐ Yes When? ____
Shingles? ☐ No ☐ Yes When? ____ Tetanus? ☐ No ☐ Yes When? ____
When was your last: Pap smear? _____ Colonoscopy? _____
Mammogram? _____ Cholesterol check? _____

Patient Name _____ Date _____/_____/_____

Past Medical History and Review of Systems

(Please circle if you have had problems with or are presently complaining of any of the following)

1. High blood pressure	13. Bronchitis	25. Change in bowel habits	37. Arthritis
2. Diabetes	14. Pneumonia	26. Ulcers	38. Low back pain
3. Cancer	15. Persistent cough	27. Hemorrhoids	39. Skin disease
4. Heart disease	16. T.B.	28. Gall bladder disease	40. Blood disorders
5. Chest pain/tightness	17. Hay fever	29. Colitis	41. Venereal disease
6. Shortness of breath	18. Abdominal pain	30. Hepatitis or jaundice	42. Anxiety
7. Swollen ankles	19. Indigestion	31. Thyroid disease	43. Depression
8. Palpitations	20. Nausea	32. Head or neck radiation	44. Anemia
9. Lightheadedness	21. Vomiting	33. Headache	45. Alcohol abuse
10. Frequent Urination	22. Constipation	34. Kidney disease	46. Drug abuse
11. Rheumatic fever	23. Diarrhea	35. Kidney stones	47. Gout
12. Asthma	24. Blood in stool	36. Difficulty urinating	48. _____

(explain)_____
_____
_____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Mental disease (anxiety, depression)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding disorders	_____	_____
Other:_____	_____	_____

Prevention

Do you wear seat belts?	□ No □ Yes	If no, why not?_____
Do you smoke?	□ No □ Yes	If yes, how many packs per day?
Do you drink alcoholic beverages?	□ No □ Yes	If yes, how many per week?
Do you drink coffee or tea?	□ No □ Yes	If yes, how many per day?
Is there a gun in your home?	□ No □ Yes	□ N/A
Do you use drugs? (marijuana, cocaine, etc)	□ No □ Yes	If yes, explain_____
Have you ever engaged in activities that have put you at risk of getting AIDS?	□ No □ Yes	If yes, explain_____
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	□ No □ Yes	If yes, explain_____
Are you in a relationship in which you have been physically hurt by your partner?	□ No □ Yes	
Do you ever feel afraid of your partner?	□ No □ Yes	
Do you have a "living will"?	□ No □ Yes	

Method of birth control? _____

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PATIENT RECORD OF DISCLOSURE

Dear Patient,

Your right to privacy is very important to us. To help ensure your privacy we would like to know your preferences regarding communications from our office.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____

- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ Mail to my home address
- ☐ Mail to my work/office address
- ☐ Fax to this number _____

☐ Cell Phone/Mobile phone_____

- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____

- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

☐ I also give permission to Suburban Medical Group to disclose my protected health information to the designated person(s) listed below:

_____
Print Name(s)

_____
Email address

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate