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? ________________________________

Suburban Medical Group

# 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