GONZAGA FAMILY HEALTH

PATIENT INFORMATION	
Full Name:	Sex: M F Date of Birth: ____/____/____
Street Address:	SSN: Marital Status:
City: State: Zip:	Employer:
Home:	Occupation:
Cell:	Work Phone:
e-mail:	Are you of Hispanic/Latino decent? Y N Dc
Race:	Current Primary Care Provider:
Will you be responsible for billing, or someone else?	Myself Someone Else
If someone else is responsible for billing, who?	Name and Relationship:
Person responsible for billing phone/cell:	

SPOUSE OR PARTNER	
If you have a spouse, partner, etc., please indicate if the address information is the same or different, and then fill in the information below. If no spouse, partner, etc., leave this section blank.	
Spouse/Partner Name:	
Is the address the same as above? Y N	If no, provide relevant contact information below.
Street:	Spouse/Partner Occupation:
City: State: Zip:	Spouse/Partner Contact #:
Spouse/Partner e-mail:	

INSURANCE INFORMATION	
Primary Insurance Name:	Secondary Insurance Name (if none, leave this side blank)
Is the address of the insurance subscriber the same as above? Y N	If no, provide relevant address of the subscriber below.
Member ID:	Member ID (secondary):
Group ID:	Group ID (secondary):
Name of policy holder:	Name of policy holder (secondary):
Policy holder's date of birth:	Policy holder's date of birth (secondary):

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EMERGENCY CONTACT INFORMATION	
Who should we contact in case of an emergency?	First Name: _____ Last Name:_____
Is the address the same as your (the patient's) address? Y N If no, please provide the address of the emergency contact person below.	
Phone number of emergency contact:	Home: Cell:
E-mail of the emergency contact:	
Pharmacy Name:	Location/Phone #:

MEDICATIONS	
Please list all of your current medications **and the dosage**, including medications and supplements that don't require a prescription (like Advil, fish oil supplements, etc.). You can get a medication list from your pharmacy.	
Medications	Dosage
Do you have any allergies to medications? If so, list the medication and the type of reaction you have.	

SOCIAL HISTORY		
Are you currently employed?	Yes	No
Are you able to care for yourself?	Yes	No
Do you have an advanced directive?	Yes	No
Do you drink alcohol? If yes, please indicate how many drinks per week here:	Yes	No
Do you have a history of substance abuse? If yes, please write the details here:	Yes	No
Do you smoke? If yes, please indicate how many cigarettes you smoke per day here:	Yes	No
Do you use chewing tobacco? If yes, please indicate how often you chew here:	Yes	No

SURGICAL HISTORY
Please list all past surgeries, the hospital that performed the surgeries, and the approximate date. If you don't have any past surgeries to list, please leave write "N/A" below.

This next part will be a long list asking if you or an immediate family member has had any of these conditions. Even though the list is long, we ask these questions to make sure that we can provide you with the best care possible.

PAST MEDICAL HISTORY. PLEASE INDICATE WHETHER OR NOT YOU HAVE A HISTORY OF THE CONDITIONS BELOW, OR IF AN IMMEDIATE FAMILY MEMBER (MOTHER, GRANDMOTHER, SISTER, BROTHER, ETC.) HAS A HISTORY OF THE FOLLOWING:					
Issue	Self (circle)		Immediate Family (circle)		Family Relationship
ADD/ADHD	Y	N	Y	N	
AIDS/HIV	Y	N	Y	N	
Abuse/domestic violence	Y	N	Y	N	
Allergies/hay fever	Y	N	Y	N	
Anemia	Y	N	Y	N	
Anesthesia complications	Y	N	Y	N	
Anxiety disorder	Y	N	Y	N	
Arthritis	Y	N	Y	N	
Asthma	Y	N	Y	N	
Autism spectrum disorder	Y	N	Y	N	

PAST MEDICAL HISTORY Continued....					
Issue	**Self**		**Immediate Family**		**Family Relationship**
Bedwetting	Y	N	Y	N	
Birth defects or inherited disease	Y	N	Y	N	
Bladder or kidney problems	Y	N	Y	N	
Blood diseases	Y	N	Y	N	
History of blood transfusion	Y	N	Y	N	
Breast cancer	Y	N	Y	N	
Breast problem	Y	N	Y	N	
COPD	Y	N	Y	N	
Cancer	Y	N	Y	N	
Chicken pox	Y	N	Y	N	
Chronic ear infections	Y	N	Y	N	
Congenital anomalies	Y	N	Y	N	
Congestive heart failure	Y	N	Y	N	
Constipation	Y	N	Y	N	
Coronary artery disease	Y	N	Y	N	
Depression	Y	N	Y	N	
Developmental or behavioral disorders	Y	N	Y	N	
Diabetes	Y	N	Y	N	
Difficulty swallowing	Y	N	Y	N	
Diverticulitis	Y	N	Y	N	
Ear or hearing problems	Y	N	Y	N	
Eating disorders	Y	N	Y	N	
Eczema	Y	N	Y	N	
Endometriosis	Y	N	Y	N	
Fibromyalgia	Y	N	Y	N	
GI problems	Y	N	Y	N	
Gout	Y	N	Y	N	
Head injury/concussion	Y	N	Y	N	
Frequent headaches	Y	N	Y	N	
Heart problems	Y	N	Y	N	

PAST MEDICAL HISTORY Continued....					
Issue	Self		Immediate Family		Family Relationship
Hepatitis	Y	N	Y	N	
High cholesterol	Y	N	Y	N	
Hypertension	Y	N	Y	N	
Hypothyroidism	Y	N	Y	N	
Infertility	Y	N	Y	N	
Kidney Disease	Y	N	Y	N	
Kidney Stones	Y	N	Y	N	
Liver Disease	Y	N	Y	N	
Mental disorder	Y	N	Y	N	
Muscle, joint, or bone problems	Y	N	Y	N	
Obesity	Y	N	Y	N	
Osteoporosis	Y	N	Y	N	
Ovarian cancer	Y	N	Y	N	
Polyps	Y	N	Y	N	
Pulmonary embolism	Y	N	Y	N	
Reflux/GERD	Y	N	Y	N	
Seizures or Epilepsy	Y	N	Y	N	
Skin problems	Y	N	Y	N	
Stroke	Y	N	Y	N	
Tuberculosis	Y	N	Y	N	
Varicosities	Y	N	Y	N	
vision or eye problems	Y	N	Y	N	

Thank you for taking the time to fill out this form as well as the others. We know it's a lot, but the more information we have the better your provider will be able to serve you and your family.