Doylestown Health

Primary Care

DATE_____

PATIENT INFORMATION-

Patient Name: _____ Date of Birth: _____ Male ☐ Female ☐

Previous Last Name: _____ Marital Status: S M D W DP

Nickname: _____ Spouse Name: _____

Parent/Legal Guardian Name: _____

State/Country of Birth: _____ Special Communication Needs: _____

Race: _____ Decline ☐ / Ethnicity: _____ Decline ☐ / Language: _____ Decline ☐

YOUR CONTACT INFORMATION- **Copy of Driver's License Provided ☐**

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

I prefer reminders to be made in the form of: ☐Phone Call; ☐ I do not want reminders

I request messages left for me ☐be only to return your call; ☐contain detailed information; ☐left on my voicemail; ☐sent via email if available; ☐never left- only delivered to me personally

INSURANCE INFORMATION- **Copy of Insurance Cards Provided ☐**

Subscriber Name (First Last) and Date of Birth _____

Primary Insurance: _____ I.D. Number: _____

Group Number: _____ Referral required? Yes ☐ No ☐

Claims Address: _____

Secondary Insurance: _____ I.D. Number: _____

Group Number: _____ Referral required? Yes ☐ No ☐

Claims Address: _____

Do you have an Rx Plan? Yes ☐ No ☐ / If yes, which one? _____

Preferred Pharmacy _____ City _____ Telephone # _____

EMERGENCY CONTACT INFORMATION-

Name:	Relationship:	Phone Number:	Address:

I hereby authorize ***Doylestown Health Primary Care*** *to release my PHI (protected health information) to:*

Myself Only ☐

Name:	Relationship:	Purpose:

I have an Advanced Directive: Living Will ☐ Durable Power of Attorney ☐

Name:	Relationship:	Phone Number:	Date:

Please complete all fields. If it does not apply please list N/A.

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY-

Reconciled ☐

Do you Smoke: ☐ YES ☐ NO How Much: _____ How Long: _____ Does anyone in your home smoke? ☐YES ☐NO	Do you drink Alcohol: ☐ YES ☐ NO How Much: _____ How Long: _____	Are there Guns in your House: ☐ YES ☐ NO Are they properly secured? ☐ YES ☐ NO
Do you exercise regularly? ☐ YES ☐ NO How Often:	Is everyone in your home properly immunized? ☐ YES ☐ NO	Are you in an abusive relationship or afraid of your partner? ☐ YES ☐ NO
Do you wear your seatbelt? ☐ YES ☐ NO	Blood Transfusion: ☐ YES ☐ NO If yes, Date: Reason:	Are you at Risk for HIV: ☐ YES ☐ NO Behavior:
Do you have working smoke detectors in your home? ☐ YES ☐ NO	Drink Coffee/Tea: ☐ YES ☐ NO # of Cups per day:	Use(d) Drugs: ☐ YES ☐ NO Describe:

Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling depressed or hopeless	0	1	2	3

Please choose either Yes or No for the following questions.

Yes ☐ No ☐ - Have you fallen in the past year?
Yes ☐ No ☐ - Are walkways free of clutter?
Yes ☐ No ☐ - Do floor coverings have frayed or rolled edges?
Yes ☐ No ☐ - Is it difficult to get off a chair or toilet?
Yes ☐ No ☐ - Are all the lights in your home bright enough for you to see clearly?
Yes ☐ No ☐ - Do you like your job, school or being retired?
Yes ☐ No ☐ - Can you switch a light on/off easily from your bed?
Yes ☐ No ☐ - Have you ever worked with chemicals, paints, asbestos or other hazardous materials?
Yes ☐ No ☐ - Are you an Organ Donor?
Yes ☐ No ☐ - Are you a Veteran?

FAMILY HISTORY-

Reconciled ☐

	Current Age/ Deceased	High Blood Pressure	Heart Disease	Stroke	Cancer	Diabetes	Glaucoma	Asthma	Seizures	Bleeding Disorder
Father		☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother		☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling		☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling		☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling		☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling		☐	☐	☐	☐	☐	☐	☐	☐	☐

ADDITIONAL NOTES-

Reviewed by Physician: _____ Date: _____

Patient Name: _____ Date of Birth: _____

PHYSICIAN INFORMATION-(Please provide first and last names)

Cardiologist: _____ Eye Doctor: _____

Gynecologist: _____ Endocrinologist: _____

Urologist: _____ Other: _____

HEALTH HISTORY- Have you ever been diagnosed with: **Reconciled ☐**

Check ALL that apply:	☐ Ulcer	☐ Tuberculosis	☐ Anemia	☐ Depression
☐ Mumps	☐ Hepatitis	☐ Thyroid Disorder	☐ Polio	☐ Anxiety
☐ Chicken Pox	☐ Gall Bladder	☐ High Blood Pressure	☐ Seizures	☐ Gout
☐ Diabetes	☐ Reflux Disease	☐ Stroke	☐ Kidney Disease	☐ Lyme Disease
☐ Asthma	☐ Pancreatitis	☐ Heart Attack	☐ Kidney Stone	☐ Prostate Disease
☐ Pneumonia	☐ Colitis	☐ Heart Failure	☐ Arthritis	☐ Glaucoma
☐ Emphysema	☐ Diverticulitis	☐ High Cholesterol	☐ Irritable Bowel	☐ Osteoporosis
☐ Cancer Type:_____	☐ Scarlet Fever	☐ Heart Murmur	☐ Menstrual Problems	☐ Venereal Disease Type:_____

When was your last...?

Well Exam: _____ Colonoscopy: _____ Tetanus: _____

Mammogram: _____ Pap Smear: _____ Dexa Scan: _____

PSA: _____

Which hand do you mainly use to perform tasks like writing? Right ☐ Left ☐

Do you need assistance with activities of daily living (Eating, Dressing, Hygiene, Housekeeping)? Yes ☐ No ☐

Do you wish to be screened for:

HEP C Yes ☐ No ☐ If yes, were you born between 1945-1965? Yes ☐ No ☐

HIV Yes ☐ No ☐

TB Yes ☐ No ☐

MEDICATIONS WITH DOSAGES- None ☐ See Attached ☐ **Reconciled ☐**

ALLERGIES- No Known Drug Allergies ☐ See Attached ☐ Latex: Yes ☐ No ☐ **Reconciled ☐**

SURGICAL HISTORY- None ☐ See Attached ☐ **Reconciled ☐**

Procedure:	Date: