Patient Information

Record #	Social Security #	Date

First Name	Last Name	MI

Date of Birth	Gender M / F	Address	City	State	Zip Code

Would you like to sign up for MyCFMchart? ☐Yes ☐No	Would you like to sign up for CFM's monthly electronic health newsletters? ☐Yes ☐No	Marital Status ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated

Primary Physician	Pharmacy

Preferred Language	Employer	Race ☐American Indian ☐Black/African American ☐Asian ☐Native Hawaiian ☐Prefer Not to Answer ☐Other Pacific Islander ☐White

Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Prefer Not to Answer	Phone Number	Cell Number	How did you hear about us?

Living Will? ☐Yes ☐No	Email Address

EMERGENCY CONTACT INFORMATION

Please provide at least one emergency contact person below. There may also be times when you would like to give another person permission to discuss your treatment/care at Center for Family Medicine. I give my authorization to share information verbally regarding my treatment/care at Center for Family Medicine with the following:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Emergency Contact? ☐Yes ☐No Emergency Contact? ☐Yes ☐No

Authorization for discussion of treatment? ☐Yes ☐No Authorization for discussion of treatment? ☐Yes ☐No

_____

Signature Date

If Patient is a MINOR:

MOTHER **FATHER**

Name: _____ Name: _____

Date of Birth: _____ Date of Birth: _____

Social Security Number: _____ Social Security Number:

_____

Signature Relationship to Patient

Medical History

Preventative Care

Immunizations (list date of last dose):

Tetanus _____ Flu Shot _____ Pneumonia Vaccine _____ Shingles Vaccine _____

Have you had a colonoscopy? ☐Yes ☐No Date/Location _____

Have you had a bone densitometry? ☐Yes ☐No Date/Location _____

Have you had a dental exam? ☐Yes ☐No Date/Location _____

Have you had an eye exam? ☐Yes ☐No Date/Location _____

FEMALES

Have you had a mammogram? ☐Yes ☐No
Date/Location _____

Have you had a pap smear? ☐Yes ☐No
Date/Location _____

Other concerns: _____

OB/Maternity History	
Number of Pregnancies	
Number of Births	

MALES

Have you had a prostate exam? ☐Yes ☐No
Date/Location _____

Have you had a prostate blood test? ☐Yes ☐No
Date/Location _____

Other concerns: _____

Substance Use

Tobacco Use (smoke or smokeless)? ☐Yes ☐No Amount/Day _____

Alcohol Use? ☐Yes ☐No Amount/Day _____

Other Substance? ☐Yes ☐No Type/Amount _____

Comments

_____

_____

_____

_____

_____

_____

Signature Date

Medical History

You	History	Mom	Dad	Other
☐	Asthma	☐	☐	☐
☐	Cancer	☐	☐	☐
☐	COPD	☐	☐	☐
☐	Coronary Artery Disease	☐	☐	☐
☐	Diabetes	☐	☐	☐
☐	High Cholesterol	☐	☐	☐
☐	High Blood Pressure	☐	☐	☐
☐	Kidney/Renal Disease	☐	☐	☐
☐	Mental Illness	☐	☐	☐
☐	Stroke	☐	☐	☐

You	History	Mom	Dad	Other
☐	Thyroid Disease	☐	☐	☐
☐	Anemia	☐	☐	☐
☐	(Gastric)Peptic Ulcer	☐	☐	☐
☐	Heart Disease	☐	☐	☐
☐	Rheumatic Fever	☐	☐	☐
☐	Tuberculosis	☐	☐	☐
☐	Seizures	☐	☐	☐
☐	Hepatitis	☐	☐	☐
☐	HIV/AIDS	☐	☐	☐
☐	Eye Disorders	☐	☐	☐

Other Medical Conditions (please list):

Surgical History (please list year/location if known):

Current Medications:

Allergies (please list type of reaction):

Name

Patient Number