PATIENT NAME _____ Date of Birth / / Is patient a minor? o YES o NO

Parent/ Guardian Name_____ Phone number_____
(If minor)

May we leave detailed patient information on your voicemail? o Yes o No Phone number _____

Emergency Contact _____ Phone number _____

Ethnicity o Hispanic / Latino
o Not Hispanic/Latino
o Decline

Race o African American o Asian
o Caucasian / White o Native American
o Pacific Islander o Decline

Primary Household Language
o English o Spanish o Other
_____

Which Provider are you seeing? _____

What is your preferred Pharmacy_____City _____

Condition	Self	Mother	Father	Siblings
None				
Adopted				
Alcoholism				
Anemia				
Anxiety				
Arthritis				
Asthma				
Atrial Fibrillation				
Benign Prostatic Hypertrophy				
Bipolar				
Bleeding Disorder				
Cancer				
Chronic Pain				
Coronary Artery Disease				
COPD (Emphysema)				
Crohn's Disease				
Depression				
Diabetes				
Eating Disorder				
Gallbladder Disease				
GERD (Reflux)				
Glaucoma				
Gout				
Headache / Migraines				
Heart Attack				
Hepatitis C				
High Blood Pressure				
High Cholesterol				
HIV/Aids				

Condition	Self	Mother	Father	Siblings
Irritable Bowel Syndrome				
Kidney Disease				
Liver Disease				
Mononucleosis				
Multiple Sclerosis				
Osteoarthritis				
Osteoporosis				
Peptic Ulcer Disease				
Scoliosis				
Seizures				
Stroke				
Thyroid Disease				
Tuberculosis (TB)				
Other (please list)				

Is your mother living? o Yes o No o Unknown
Date of Death / / Age_____Cause_____
Is your father living? o Yes o No o Unknown
Date of Death / / Age _____Cause_____

Exercise Activity
o Sedentary o Moderate o Vigorous
How many times per week do you exercise? _____

Assistive Devices
Glasses? o Yes o No Contacts? o Yes o No
Hearing Aid(s)? o Yes o No Other? _____

Substance Exposure
Do you drink **alcohol**? o Yes o No Frequency_____
Do you use **tobacco or nicotine**? o Yes o No Frequency_____
Are there smokers in the house? o Yes o No
Recreational drug use? o Yes o No o Exposure to household user
Substance name_____ Frequency _____

Caffeine Use
o Yes o No Frequency_____

List all **MEDICATIONS** and dosage you currently take

List all **VITAMINS** and dosage you currently take.

List all **ALLERGIES** and reaction

Last Dental Exam: _____

Hospitalizations

Year	Reason

Surgeries

YEAR	Reason

WOMEN ONLY

Have you had any of the following screenings done in the last 10 years?

o Mammogram **Date of last Annual or**

o Papsmear **Medicare Annual**

o Dexa scan **___/____/_____**

o Colonoscopy

Where were screenings completed?

_____

Date of last Period _____/_____/_____

No. of pregnancies _____ Date of first birth ___/____/____

No. of Deliveries _____ Vaginal _____ C-section _____

I understand the above information and attest that this information is accurate and complete to the best of my knowledge.

_____

Signature Date

MEN ONLY

Have you had any of the following screenings done in the last 10 years?

o PSA **Date of last Annual or**

o Dexa Scan **Medicare Annual**

o Colonoscopy **___/____/_____**

Where were screenings completed?

_____

Vaccinations

Tetanus _____

Pneumonia _____

Covid vaccine/ Booster _____

Flu vaccine _____

Shingles _____

Thank you for choosing Sapphire Community Health!

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