Medical Record Number: _____

utica park clinic

Patient Information

Legal Name (Last / First / Middle)			Nickname

Social Security Number	Birth Date	☐ Male ☐ Female	Marital Status ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed

Street Address	Zip	City	State

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Preferred Contact Method ☐ Text ☐ Phone ☐ Email ☐ Other

Email **Required*	Occupation	Employer

Primary Care Provider	Referring Provider

As part of the American Recovery and Reinvestment Act, healthcare providers are required to obtain the following information. Please check the boxes in section 1-3 that most apply to you.

1. Race (Choose One)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White / Caucasian

2. Ethnicity (Choose One)

☐ Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Declined to Specify

3. Preferred Language (Choose One)

☐ Arabic ☐ English ☐ Hebrew ☐ Korean ☐ Spanish/Castilian ☐ Urdu
☐ Bulgarian ☐ French ☐ Hindi ☐ Polish ☐ Somali ☐ Vietnamese
☐ Chinese ☐ German ☐ Italian ☐ Portuguese ☐ Swahili ☐ Declined to Specify
☐ Central Khmer ☐ Haitian ☐ Japanese ☐ Russian ☐ Thai

Responsible Party (Policy Holder) / Legal Guardian *if minor, please have parent or legal guardian complete the following.*

☐ Self

Legal Name (Last / First / Middle)	Relationship to Patient ☐ Parent ☐ Other ☐ Spouse	Birth Date

Social Security Number	Address	☐ Check here if same address as above

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

Emergency Contact

Name (Last / First / Middle)	Relationship to Patient

Address

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

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Insurance

Primary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date
Secondary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date

Medications *include over-the-counter medications and supplements.* ☐ *check box if NO medications.*

Drug Name	Dosage Strength (i.e., mg/mcg)	How many times a day?
1		
2		
3		
4		
5		
6		
7		
8		
Attach additional list if there are more medications		

Allergies ☐ *check box if there are NO medication allergies.*

Drug Name / Drug Class / Food	Reaction
1	
2	
3	
4	

Preferred Local Pharmacy

Name _____ Location _____

Phone _____ Fax _____

Medical History *check all that apply. Describe details of medical conditions in spaces below.*

☐ allergies	☐ cancer: type _____	☐ high blood pressure	☐ migraines
☐ anemia	☐ COPD (Emphysema)	☐ high cholesterol	☐ osteoporosis
☐ angina (heart pain)	☐ Crohn's Disease	☐ HIV / AIDS	☐ prostate enlarged
☐ anxiety	☐ depression	☐ irritable bowel syndrome	☐ seizures
☐ arthritis	☐ diabetes ☐ type 1 ☐ type 2	☐ kidney disease: type _____	☐ stroke
☐ asthma	☐ GERD (acid reflux)	☐ liver disease: type _____	☐ thyroid disease: type _____
☐ atrial fibrillation	☐ heart disease: type _____	☐ MI (heart attack)	☐ ulcer
☐ blood clots	☐ Hepatitis ☐ A ☐ B ☐ C		
☐ Other:			

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Surgeries *check all that apply. Describe details of surgery in spaces below.*

☐ angioplasty	☐ cataract: ☐ left ☐ right	☐ knee replacement: ☐ left ☐ right
☐ appendectomy	☐ colon surgery: type _____	☐ LASIK
☐ arthroscopy knee: ☐ left ☐ right	☐ c-section	☐ liver biopsy
☐ back surgery: type _____	☐ D&C	☐ mastectomy: ☐ left ☐ right
☐ breast biopsy: ☐ left ☐ right	☐ gallbladder	☐ ovary removed: ☐ left ☐ right
☐ breast implants	☐ gastric bypass	☐ prostate surgery: type _____
☐ breast reduction	☐ groin hernia repair: ☐ left ☐ right	☐ thyroid surgery
☐ CABG (heart vessel bypass)	☐ hip fracture repair: ☐ left ☐ right	☐ tonsillectomy
☐ cardiac pacemaker	☐ hip replacement: ☐ left ☐ right	☐ tubes tied
☐ carpal tunnel: ☐ left ☐ right	☐ hysterectomy	☐ vasectomy

**items in gray are for females only*

☐ Other:

Family History

Mother	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				
Father	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				
Brother(s)	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				
Sister(s)	☐ ADD/ADHD	☐ alcoholism	☐ allergies	☐ Alzheimer's	☐ asthma	☐ bleeding disorder
	☐ cancer: type: _____		☐ depression	☐ diabetes ☐ type 1	☐ type 2	☐ heart attack
	☐ heart disease	☐ high blood pressure	☐ high cholesterol	☐ mental illness	☐ migraines	
	☐ osteoporosis	☐ seizure	☐ stroke	☐ thyroid disease	☐ tuberculosis	
	☐ ulcerative colitis	☐ other: _____				

Social History *your answers help determine your risk for certain diseases. Responses are confidential.*

Marital Status:
☐ Divorced ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Single ☐ Widowed

Sexual Orientation:
☐ Bisexual ☐ Heterosexual ☐ Homosexual

Transgender Identity, if applicable
☐ Female to Male ☐ Male to Female ☐ Unknown

Do you have any religious or spiritual preferences that would affect your healthcare?

Tobacco Use ☐ Yes ☐ No

Do you... ☐ smoke a pipe ☐ smoke cigarettes ☐ chew tobacco

How many... packs per day? _____

years? _____

If you quit, what year? _____

Do you drink *alcohol?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you use *illegal drugs?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you use *caffeine?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

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Immunizations *list dates of most recent immunizations or attach record.*

Vaccination	Date	Date	Date
Chicken Pox			
Hepatitis A			
Hepatitis B			
HPV			
Influenza			
Meningococcal			
MMR			
Pneumonia PCV13 (Prevnar 13)			
Pneumonia PPSV23 (Pneumovax)			
Shingles			
Tetanus and Diphtheria (Td)			
Tetanus, Diphtheria, Pertussis (Tdap)			

Preventive Screenings *list dates of the most recent preventive services you've received.*

Test	Test Never Performed	Where Performed?	Last Exam Date	Findings/Results
Bone density	☐			
Blood sugar	☐			
Cholesterol	☐			
Colonoscopy	☐			
Glaucoma	☐			
Hearing	☐			
HIV	☐			
Lung cancer scan (CT of chest)	☐			
Lung scan	☐			
Mammogram	☐			
Medicare wellness visit	☐			
Prostate exam (males only)	☐			
Ultrasound aorta	☐			
Vision examination	☐			

Women's Health History

Age of first menstrual period? _____ Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly

Age of first birth? _____ Date of last mammogram? _____ Result? _____

Beginning date of last menstrual period? _____ Date of last pap smear? _____ Result? _____

If you have achieved menopause, what age? _____ What Year? _____ ☐ Natural ☐ Surgical *(choose one)*

Pregnancy History *list the number of each type in the box below.*

Full Term	Premature	C-Section	Vaginal	Live Birth	Ectopic	Miscarriage	Abortion