

# utica park clinic

<b>Patient Information</b>	Legal Name			Nickname
	Last	First	Middle	
Social Security Number		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Street Address		Zip	City	State
Primary Phone <input type="checkbox"/> Able to receive text messages		<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Other	Preferred Contact Method <input type="checkbox"/> Text <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Other	
Email <i>*Required</i>		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.

<b>1. Race (Choose One)</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White / Caucasian																													
<b>2. Ethnicity (Choose One)</b> <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Latino <input type="checkbox"/> Declined to Specify																													
<b>3. Preferred Language (Choose One)</b> <table border="0"> <tr> <td><input type="checkbox"/> Arabic</td> <td><input type="checkbox"/> English</td> <td><input type="checkbox"/> Hebrew</td> <td><input type="checkbox"/> Korean</td> <td><input type="checkbox"/> Spanish/Castilian</td> <td><input type="checkbox"/> Urdu</td> </tr> <tr> <td><input type="checkbox"/> Bulgarian</td> <td><input type="checkbox"/> French</td> <td><input type="checkbox"/> Hindi</td> <td><input type="checkbox"/> Polish</td> <td><input type="checkbox"/> Somali</td> <td><input type="checkbox"/> Vietnamese</td> </tr> <tr> <td><input type="checkbox"/> Chinese</td> <td><input type="checkbox"/> German</td> <td><input type="checkbox"/> Italian</td> <td><input type="checkbox"/> Portuguese</td> <td><input type="checkbox"/> Swahili</td> <td><input type="checkbox"/> Declined to Specify</td> </tr> <tr> <td><input type="checkbox"/> Central Khmer</td> <td><input type="checkbox"/> Haitian</td> <td><input type="checkbox"/> Japanese</td> <td><input type="checkbox"/> Russian</td> <td><input type="checkbox"/> Thai</td> <td></td> </tr> </table>						<input type="checkbox"/> Arabic	<input type="checkbox"/> English	<input type="checkbox"/> Hebrew	<input type="checkbox"/> Korean	<input type="checkbox"/> Spanish/Castilian	<input type="checkbox"/> Urdu	<input type="checkbox"/> Bulgarian	<input type="checkbox"/> French	<input type="checkbox"/> Hindi	<input type="checkbox"/> Polish	<input type="checkbox"/> Somali	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Chinese	<input type="checkbox"/> German	<input type="checkbox"/> Italian	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Swahili	<input type="checkbox"/> Declined to Specify	<input type="checkbox"/> Central Khmer	<input type="checkbox"/> Haitian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Russian	<input type="checkbox"/> Thai	
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**Responsible Party (Policy Holder) / Legal Guardian** *if minor, please have parent or legal guardian complete the following.*

☐ Self

Legal Name			Relationship to Patient	Birth Date
Last	First	Middle	<input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/> Spouse	
Social Security Number	Address			<input type="checkbox"/> Check here if same address as above
Primary Phone <input type="checkbox"/> Able to receive text messages		<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Other	Employer	

<b>Emergency Contact</b>	Name			Relationship to Patient
	Last	First	Middle	
Address				
Primary Phone <input type="checkbox"/> Able to receive text messages		<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Other	Employer	

## Insurance

<b>Primary</b> Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date
<b>Secondary</b> 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.*

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

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

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

\*items in gray are for females only

☐ Other: \_\_\_\_\_

**Family History**

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

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

<b>Marital Status:</b>	Do you drink <i>alcohol</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Married	If yes, what type?	_____
<input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	If yes, how much?	_____
<b>Sexual Orientation:</b>	If yes, how often?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
<input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual		<input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely
<b>Transgender Identity, if applicable</b>	Do you use <i>illegal drugs</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Female to Male <input type="checkbox"/> Male to Female <input type="checkbox"/> Unknown	If yes, what type?	_____
Do you have any religious or spiritual preferences that would affect your healthcare?	If yes, how much?	_____
	If yes, how often?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
		<input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely
<b>Tobacco Use</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use <i>caffeine</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you... <input type="checkbox"/> smoke a pipe <input type="checkbox"/> smoke cigarettes	If yes, what type?	_____
<input type="checkbox"/> chew tobacco	If yes, how much?	_____
How many... packs per day? _____	If yes, how often?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
years? _____		<input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely
If you quit, what year? _____		

**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	<input type="checkbox"/>			
Blood sugar	<input type="checkbox"/>			
Cholesterol	<input type="checkbox"/>			
Colonoscopy	<input type="checkbox"/>			
Glaucoma	<input type="checkbox"/>			
Hearing	<input type="checkbox"/>			
HIV	<input type="checkbox"/>			
Lung cancer scan (CT of chest)	<input type="checkbox"/>			
Lung scan	<input type="checkbox"/>			
Mammogram	<input type="checkbox"/>			
Medicare wellness visit	<input type="checkbox"/>			
Prostate exam (males only)	<input type="checkbox"/>			
Ultrasound aorta	<input type="checkbox"/>			
Vision examination	<input type="checkbox"/>			

**Women's Health History**

Age of first menstrual period? _____	Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? _____ <input type="checkbox"/> Natural <input type="checkbox"/> 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