PATIENT INFORMATION FORM

CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

Date: _____

Patient's Name: _____ DOB: _____
Last First Middle

Maiden Name: _____

Patient's Address: _____
Street or P.O. Box

City/State/Zip: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Home Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

GUARANTOR INFORMATION *(Person responsible if the insurance doesn't pay all)*

☐ NOT Employed ☐ Self-Employed

Guarantor's Name: _____

Relation to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

Guarantor's Address: _____
Street or P.O. Box Phone Number

Guarantor's Employer: _____

Work Number: _____ Occupation: _____ ☐ Full Time ☐ Part Time

EMERGENCY CONTACT

Name: _____ Phone Number: _____

INSURANCE INFORMATION

☐ No Insurance

Name of Insurance: _____ Policy Number: _____

Group Number: _____ Group Name: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security: _____

A COPY OF THE PATIENT'S INSURANCE CARD AND PICTURE ID ARE REQUIRED.

PATIENT HEALTH HISTORY FORM

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Do you have any health concerns? If yes, please list : _____

_____

_____

_____

_____

Please Check Any Of The Following Problems That Apply To You: ____ **NO PROBLEMS**

GENERAL
- ☐ Fever
- ☐ Sweats

ALLERGY
- ☐ Seasonal
- ☐ Symptoms
- ☐ Sneezing
- ☐ Itchy eyes
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Postnasal drip

CARDIOVASCULAR
- ☐ Chest pain or pressure
- ☐ Ankle swelling
- ☐ Palpitations

ENDOCRINE
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat intolerance
- ☐ Cold intolerance

EYES
- ☐ Blurred vision
- ☐ Changing vision

GENITOURINARY
- ☐ Urinary frequency
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Awaken at night to urinate

HEMATOLOGIC
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Hard to stop bleeding

MENTAL HEALTH
- ☐ Insomnia
- ☐ Guilt
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

EAR/NOSE/THROAT
- ☐ Ear pain
- ☐ Runny nose
- ☐ Sneezing
- ☐ Postnasal drip

NUTRITION
- ☐ On a special diet
- ☐ Weight gain or loss greater than 10 pounds

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Blood in stool

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Joint pains
- ☐ Muscle pains

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Shortness of breath with exertion

SKIN
- ☐ Rash
- ☐ Changing mole
- ☐ Itching
- ☐ Slow healing wounds

NEUROLOGIC
- ☐ Numbness
- ☐ Tingling
- ☐ Headaches
- ☐ Weakness

DAILY LIVING
- ☐ Violence in your home
- ☐ Problems with sex
- ☐ Changes in functional ability
- ☐ Exposure to sexually transmitted disease
- ☐ Changes in eating habits
- ☐ Changes in sleeping habits
- ☐ Problems urinating

SOCIAL HABITS:

Have you ever smoked? ☐ Yes ☐ No Use: ☐ Current ☐ Past

Type: ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Pipe ☐ Other Number per Day: _____ Number of Years: _____

Have you ever drank alcohol? ☐ Yes ☐ No Use: ☐ Current ☐ Past Type: ☐ Beer ☐ Wine ☐ Liquor

Amount: ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week ☐ daily
☐ Several times per day

Have you ever used illegal drugs? ☐ Yes ☐ No Use: ☐ Current ☐ Past

Type: ☐ Amphetamines ☐ Inhalants ☐ Glues ☐ Solvents ☐ Cocaine ☐ Marijuana ☐ Ecstasy ☐ Hallucinogen
☐ Methamphetamines ☐ LSD ☐ Prescription Medications ☐ Heroin ☐ Other _____

Amount: ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week ☐ daily
☐ Several times per day

How many glasses/cups of caffeine do you drink daily? _____

Do you wear seat belts? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What is your occupation? _____

Are you sexually active? ☐ Yes ☐ No If so, ☐ 1 partner ☐ Multiple partners ☐ With women ☐ With men

Do you exercise? ☐ Yes ☐ No Duration (Average Number of Minutes) _____ per session?

How many times per week? ☐ 1-2 times ☐ 2-3 times ☐ 3-4 times ☐ 4-5 times ☐ 5-6 times ☐ daily

Type of exercise: ☐ Walking ☐ Aerobics ☐ Running ☐ Swimming ☐ Weight Lifting ☐ Yoga ☐ Other: _____

FAMILY HISTORY: Has anyone in your family had any of the following? (Check appropriate box)

ILLNESS	Mother If deceased, enter age at death_____	Father If deceased, enter age at death_____	Brothers/Sisters If deceased, enter age at death_____	Paternal Grandparent	Maternal Grandparent
High Blood Pressure					
Heart Attack/ Heart Surgery					
Diabetes					
Stroke					
Seizures					
COPD					
Kidney Disease					
Cancer (Type/Location)					
Osteoporosis					
Thyroid Problems					
Mental Illness					
Rheumatoid Arthritis					
Lupus					

PAST MEDICAL HISTORY: Check conditions that doctors have followed you for in the past:

☐ High blood pressure/hypertension ☐ High Cholesterol ☐ Liver Disease ☐ Diabetes ("sugar") ☐ Asthma
☐ Thyroid Problems ☐ Kidney Disease ☐ Heart Attack/By-pass Surgery ☐ COPD ☐ Ulcers ☐ Stroke
☐ Seasonal Allergies/Hay fever ☐ Heart Failure ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Migraines
☐ GI Bleed ☐ Seizures/Epilepsy ☐ Stomach Problems ☐ Intestinal Problems ☐ Reflux Disease ☐ Glaucoma
☐ Psychiatric Illness ☐ Arthritis ☐ Abnormal PAP
☐ Other:_____
☐ Cancer: Type & Location _____

List any hospitalizations: _____

_____

_____

List any surgeries, dates, and who performed them:_____

_____

_____

SCREENINGS AND IMMUNIZATIONS:

SCREENINGS	DATE	IMMUNIZATIONS	DATE RECEIVED
Mammogram		Tetanus	
Pap Smear		Pneumovax	
Colonoscopy		Shingles	
Bone Density		Hepatitis B	
PSA		PPD (TB skin test)	
Vision Screening		Fluvax	

FEMALE ONLY: How often do you examine your breasts? _____ Do you see an OB/GYN doctor? ☐ Yes ☐ No
# of pregnancies_____ # of live births_____

MALE ONLY: Do you do self-testicular exams? ☐ Yes ☐ No Do you have any problems with erections? ☐ Yes ☐ No

List any Allergies:_____

_____

_____

List ALL CURRENT MEDICATIONS (including over the counter, vitamins, herbal, and health food preparations):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Are Blood Transfusions Acceptable to Patient in Emergencies? ☐ Yes ☐ No

How many people live with you? _____

Do you have: ☐ Advanced Directive ☐ Living Will ☐ Healthcare Power of Attorney

How do you learn best? ☐ Read it ☐ Tell me ☐ Show me Highest level of education completed? _____

Have you fallen in the past 30 days? ☐ Yes ☐ No

Do you feel safe at home ☐ Yes ☐ No