Memorial MEDICAL GROUP

PATIENT INFORMATION

PERSONAL INFORMATION

Name: _____
Last Name First Name Middle Initial

Date of Birth: **Social Security Number:** **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Hand Dominance: ☐Left Hand ☐Right Hand **Date of Last Physical Exam:**_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other:_____ **Primary Language:**_____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African American ☐ Native Hawaiian or Pacific Islander
☐ Somali ☐ White ☐ Other_____ ☐ Do Not Care to Respond

Home Address: _____
Street City State Zip Code

Home Phone: **Work Phone:** **Cell Phone:**

Email Address: _____

Pharmacy: _____
Name Street City State Zip Code

REFERRAL INFORMATION

Primary Care Physician: **Referring Physician:**

Physician of Record (BWC): _____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Name: _____
Last Name First Name Middle Initial

Relationship to Patient: ☐Self (*if self, skip to Emergency Contact*) ☐Spouse ☐Parent ☐Other

Home Address: _____
Street City State Zip Code

Date of Birth: **Primary Phone:** **Secondary Phone:**

Email Address: **Social Security Number:**

Primary Insurance: **Identification Number:**

EMERGENCY CONTACT INFORMATION

Name: _____
Last Name First Name Middle Initial

Relationship to Patient: ☐Spouse ☐Parent ☐Other:_____ **DOB:** _____

Home Address: _____
Street City State Zip Code

Home Phone: **Work Phone:** **Cell Phone:**

Oftentimes we may need to contact you regarding your medical care or any related concerns. In an effort to protect your privacy, we have established a procedure we will follow when leaving messages:

- We will ***NOT*** leave messages with anyone except the patient or legal guardian.
- We will ***NOT*** leave any messages on your voicemail or answering machine.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

I, _____ authorize Memorial Medical Group to speak with and/or leave messages regarding my medical care with the contacts and/or the numbers listed below. I fully understand that this consent will remain valid until I notify otherwise.

Please indicate below who we are authorized to speak with regarding your care.

Contact Name	Phone Number	Relationship
1.		
2.		
3.		

Please indicate below the numbers in which we are authorized to leave messages regarding your care.

My **CELLPHONE** voicemail phone number: _____

My **HOME** answering machine phone number: _____

My **OFFICE/WORK** phone number: _____

Do you have a Legal Guardian or Power of Attorney for Healthcare? ☐ Yes ☐ No

Contact Name: **Contact Phone Number:**

Signature (Patient or Legal Representative):	**Date:**

I, _____ **DO NOT** authorize Memorial Medical Group to speak with anyone other than myself or leave messages regarding my medical care. I fully understand that this consent will remain valid until I notify otherwise.

Signature (Patient or Legal Representative):	**Date:**

Memorial MEDICAL GROUP

HISTORY FORM

Patient Name: **Date of Birth:**

Chief Complaint (s) Reason for your visit

1.
2.
3.
4.
5.

Allergies: (please circle all that apply)

Aspirin	Vicodin	Codeine
Penicillin	Percocet	Latex
Sulfa	Topical Iodine	IV Contrast

Other(s): _____

_____

Hospitalization / Surgical History

Hospitalization / Surgery	Date / Year

Social History

Type:			Amount Daily	Years
Alcohol	Yes	No		
Caffeine	Yes	No		
Illegal Drugs	Yes	No		
Marijuana	Yes	No		
Tobacco	Yes	No	Packs:	

Immunization History

Immunization	Date / Year
Hepatitis A	
Hepatitis B	
Human Papillomavirus (HPV)	
Influenza	
Measles, Mumps, Rubella (MMR)	
Pneumonia	
Prevnar 13	
Tetanus, Diphtheria, Pertussis (Tdap)	
Varicella	
Zoster (Shingles)	
Tetanus	

Examination / Test History

Examination / Test	Date / Year	Result (abnormal, normal, high, low)
Bone Density		
Breast Exam		
Cholesterol		
Colonoscopy		
Eye Exam		
Hearing Test		
Hemoglobin A1C		
Mammogram		
PAP / Pelvic Exam		
PSA Screening		
TB Test		

Patient Name: **Date of Birth:**

Past Medical History *(check all that apply)*	
☐ AIDS/HIV	☐ Infectious Mono
☐ Allergies	☐ Kidney Disease
	☐Learning Disorder
☐ Anemia	☐Measles
☐ Arthritis	☐Migraines
☐ Asthma	☐Mumps
☐ Back Pain	☐Neuropathy
☐ Bladder Infection	☐Osteoporosis
☐ Blood Clots/ DVTs/ Pulmonary Embolus	☐Pneumonia
☐ Bronchitis	☐Polio
☐ Cancer Type:	☐Pulmonary/ Respiratory Disease
☐ Chicken Pox	☐Rheumatic Fever
☐ Diabetes	☐Scarlet Fever
☐ Diphtheria	☐Sleep Apnea
☐ Eczema/ Hives	☐Small Pox
☐ Epilepsy	☐Stroke
☐ Glaucoma	☐Thyroid Disease
☐ Heart Attack	☐Tuberculosis
☐ Hemorrhoids	☐Transfusions
☐ Hepatitis	☐Ulcer
☐ Hernia	☐Sexually Transmitted Disease
	☐Sickle Cell Disease
☐ High Blood Pressure	☐Whooping Cough
☐Other:	
☐ Other:	

Family History *(check all that apply)*	**Relationship**
☐Allergies	
☐Alzheimer's	
☐Anemia	
☐Cancer (see below) Type:	
☐Dementia	
☐Diabetes	
☐Epilepsy	
☐Glaucoma	
☐Heart Disease	
☐Hypertension	
☐Parkinson's	
☐Stroke	
☐Tuberculosis	
☐Other:	
☐Other:	
☐Other	

***Women Only**	
Are you currently pregnant? ☐Yes ☐No	
Are you currently breastfeeding? ☐Yes ☐No	
Age of First period:	Pregnancies (#):
Date of Last period:	Miscarriages (#):
Birth Control:	Abortions (#):

Patient Name: **Date of Birth:**

Current Medications *(Please include over the counter medications, herbal supplements, vitamins, etc.)*		
Medication:	**Dosage:**	**Directions:**

List any Specialists you have seen and the medical condition they have diagnosed		
Specialist Name:	**Condition:**	**Date:**