PROVIDER CARE

PATIENT INFORMATION

Patient

Date: _____

Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Email address: _____

Patient's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

Spouse's name: _____ Spouse's DOB: _____ Spouse's SSN: _____

Spouse's occupation: _____ Employer: _____

Employer's address: _____ Employer phone: _____

In case of emergency, notify: _____ Relationship: _____

City: _____ State: _____ Phone: _____

If patient is a minor, list person/s other than emergency contact above who have permission to bring child to office for treatment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance *(provide patient information unless patient is a minor, then provide guarantor's information)*

PRIMARY INSURANCE

Insurance name: _____ Relationship to patient: _____

Subscriber's name: _____ Copay amount: _____

Subscriber ID/Contract Policy #: _____ Group #: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employer's Phone: _____

SECONDARY INSURANCE

Insurance name: _____ Relationship to patient: _____

Subscriber's name: _____ Copay amount: _____

Subscriber ID/Contract Policy #: _____ Group #: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Subscriber's Employer: _____ Employer's Phone: _____

Person responsible for this account: _____ Phone: _____

I acknowledge that payment is due at the time of service. I agree to covering all co-pays, charges not covered, routine charges, deductibles, and co-insurance amounts that may be applicable. Should this account be referred to a collection agency, I understand that I will bear the responsibility for all associated collection fees, court costs, and attorney's fees. I grant authorization to SHA Diabetes Center to disclose information to insurance carriers and allow insurance carriers to share relevant information with SHA Diabetes Center regarding my illness, treatment, and payments, including workmen's compensation. I hereby assign to the physician all payments for medical services provided to either myself or my dependents if such assignment is applicable.

_____ _____ _____

Signature Date Time

PROVIDER CARE

MEDICAL HISTORY WORK-UP SHEET

Date: _____ Appointment with: _____

Name: _____ Date of birth: _____ Age: _____

What other doctors/specialists do you see? Name/Specialty: _____

_____

Reason for visit: _____

Any new or worsening problems? If yes, please describe: _____

_____

PAST MEDICAL HISTORY *(Please check if you have any of the below.)*

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disease (Lupus)
- ☐ Biliary Cirrhosis
- ☐ Bipolar Disorder
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ COPD (Lung Disease)
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot in Legs)
- ☐ Eczema
- ☐ GI Bleed
- ☐ Gerd (Acid Reflux)
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Insomnia
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ MI (Heart Attack)
- ☐ Migraine Headaches
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD (Stomach Ulcers)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Nodule
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ UTI - Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Gestational Diabetes
- ☐ Rh Sensitized
- ☐ Sleep Apnea

Using a CPAP?

Other_____

PAST SURGICAL HISTORY

- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Aortic Valve Replaced
- ☐ Appendectomy
- ☐ Both Legs Bypassed
- ☐ Back Surgery
- ☐ Bronchoscopy (Lung Scope)
- ☐ CABG (Heart Bypass)
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Right / Left
- ☐ Cataract Extraction
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Gallbladder Removed
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement Right / Left
- ☐ Invasive Pain Procedure
- ☐ Kidney Transplant Right / Left
- ☐ Knee Arthroscopy Right / Left
- ☐ Knee Replacement Right / Left
- ☐ Kyphoplasty
- ☐ Mitral Valve Replaced
- ☐ Nephrectomy Right / Left
- ☐ Pacemaker Implanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy Right / Left
- ☐ PTCA (Angioplasty)
- ☐ Rotator Cuff Repair Right / Left
- ☐ Abdominal Hysterectomy
- ☐ Ovaries Removed Yes / No
- ☐ Prostate Surgery
- ☐ Shoulder Surgery Right / Left
- ☐ Sleep Apnea Surgery
- ☐ Thyroid Surgery
- ☐ Tonsil's Removed
- ☐ Vascular Surgery
- ☐ Breast Augmentation Right / Left
- ☐ Mastectomy Right / Left
- ☐ Lumpectomy Right / Left

Other_____

Patient name: _____ DOB _____

FAMILY HISTORY	Father	Mother	Brother	Sister	Children
High Blood Pressure	☐	☐	☐	☐	☐
Heart Artery Disease/Heart Attack	☐	☐	☐	☐	☐
Kidney Disease (Chronic)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Cancer (Type)	☐	☐	☐	☐	☐

SOCIAL HISTORY *(Check or circle appropriate)*

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Work ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Disabled Occupation:_____

Children: Religious Affiliation _____

ALLERGIES OR MEDICATION REACTIONS ☐ **NO KNOWN DRUG ALLERGIES**

Allergic to: Reaction:

_____

_____

_____

RISK FACTORS *(Check or circle appropriate)*

☐ Current tobacco use Year started _____

Type of tobacco: Cigarettes / Cigars / Snuff / Vapor

☐ Former tobacco use Year quit _____

☐ Never smoked

Second hand smoke

Do you wear a seat belt?

Multiple sexual partners?

Caffeine Use

How many drinks per day _____

Alcohol use

How many per day? _____ Type _____

Exercise

Times per week _____ Type _____

CURRENT MEDICATIONS ☐ **REFER TO LIST** ☐ **REFER TO BOTTLES**

Please include the dose and how often you take the medication. *(Skip if you brought a list or bottles)*

Name	Dosage	How many times per day?	As Needed (PRN)

Pharmacy_____ Phone #_____ Location_____

Do we have permission to receive medication history on patient via electronic prescription?

Signature of patient/guardian _____ Date _____

Patient name: _____ DOB _____

MEDICAL PROBLEMS Have you had any recent or persistent problems with the following?

General

- ☐ Weight Gain/Loss
- ☐ Fever/Chills/Fatigue
- ☐ Snoring
- ☐ Sleep Troubles
- ☐ Depression/Anxiety

Endocrine

- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ High Blood Sugars
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Loss of Sensation in the Feet

Please enter the most recent date and results of the following:

	Date	**Results**	**Performed by (who/where)**
Colonoscopy	_____	_____	_____
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Bone Density Scan	_____	_____	_____
Menstrual Period	_____	_____	_____
PSA (Prostate Screen)	_____	_____	_____
Diabetic Eye Exam	_____	_____	_____
Diabetic Foot Exam	_____	_____	_____
Last HgB A1c Level	_____		