PATIENT INFORMATION SHEET

NAME:_____ GENDER:_____ DOB:_____ DATE: _____
ALLERGIES: _____

_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer:_____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date:	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type:_____Amount/day:_____Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type:_____

Are you sexually active? ☐Yes ☐ No Sexuality:_____

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:_____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age_____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:_____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

For what reason are you here today?_____

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature:_____ Date: _____

Patient Information

Patient Information

First Name:	Last Name: M.I.:	Previous Name (if applicable)
Mailing Address: Apt #		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) O Voice O Text / Email		If Voice, Please Select Preferred Number: O Home O Cell O Work
Email Address:	Date of Birth:	Sex: Female Male
Marital Status:	Social Security #:	
Employer Name:	Emergency Contact Name:	
Emergency Contact Phone #:	Relationship to Patient:	

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** O Yes O No
Race (please select): O White O American Indian or Alaska Native O Asian O Hispanic O Black or African American O Native Hawaiian or Pacific Islander O Other O Decline	**Ethnicity (please select one):** O Hispanic or Latino O Not Hispanic or Latino O Decline
Preferred Language (please select one): O English O Bosnian O Sign Language O Spanish	O Indian (including Hindi & Tamil) O Russian O Other
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name Ins. ID NUMBER	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

NEW MEXICO FAMILY CLINIC PRIVACY ACKNOWLEDGMENT CONSENT:

I,_____give New Mexico Family Clinic my consent to use or disclose my protected health information, to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality review. I have been informed that I may review the clinics' notice of privacy practices for a more complete description of uses and disclosures before signing this consent. I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic. I understand that I have the right to request a restriction of how my private health information is used. However, I also understand that the clinic is not required to agree to this request. If the clinic agrees to my requested restriction they must follow the restriction. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

I have reviewed the above copy of NMFC's Privacy Acknowledgment Form: (Initials)_____

Signature of Responsible Party: **X** _____ **Date:** _____

Printed Name of Responsible Party: **X** _____ **Date:** _____

If you would like a copy of *NEW MEXICO FAMILY CLINIC PRIVACY ACKNOWLEDGMENT CONSENT FORM* please ask the office staff.