Patient Name:_____ Date of Appointment:_____

NP Hagans Walk-In Clinic * 9135 Piscataway Rd. # 320 Clinton, MD 20735 * (240)-412-5093 (Office)

Patient Information

Patient First Name	Patient Middle Initial	Patient Last Name
Sex	Marital Status	Date of Birth
Social Security Number	Patient Address	City
State	Zip Code	Home Phone
Mobile Phone	Email address	Referred by
Primary Care Physician	Primary Care Physician Phone	Pharmacy Name
Pharmacy Phone Number	Pharmacy Address	City, State, Zip Code

Patient Employer/School Information

Employer/School	Occupation/Major	Employer/School Phone
Employer/School Address	City	State, Zip Code

Emergency Contact

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Insurance/Billing Information

Primary Insurance	Plan	Plan Number
Group Number	Insured's Employer/School	Insured's Name (as it appears on card)
Relation to patient	Insured's Phone #	Insured's Address
City:	State:	Zip Code:
Insured's Social Security Number	Insured's Date of Birth	

Responsible Party

Billing Name	Phone	Relation to patient	
Address	City	State	Zip Code

_____ _____

Signature of Patient or Authorized Guardian **Date**

Patient Name:_____ Date of Appointment:_____

What brings you into the office today?_____

Is your general health Excellent Good Fair Poor (circle one)

Please list any allergies to any medications, foods, or materials _____

Current Medications

Name	Dosage	Frequency

Past Medical History/Conditions that you have been diagnosed with by a licensed healthcare provider. Provide condition and year diagnosed.

1.	2.	3.	4.
5.	6.	7.	8.

Hospitalizations & Surgeries. Please provide name/reason for hospital admission and year of surgery.

Surgery/Hospitalization	Year
1.	
2.	
3.	

Women only

# of pregnancies	**# of Miscarriages**	**# of abortions**	**# of living children**
Last Pap Smear	**Last Mammogram**	**Birth control method**	**Last Menstrual Cycle**

Lifestyle Factors

Are you sexually active?	**Do you wish to be tested for STD's?**	**Has anyone in your home ever verbally or physically hurt you?**
Have you ever smoked? _____	**Do you smoke now? _____** **Packs per day_____**	**Do you use recreational drugs? If so, what type?** _____
How much alcohol do you drink per week? _____	**How much caffeine do you drink per week?** _____	**How often do you exercise?** _____

Patient Name:_____ Date of Appointment:_____

Family History

Has anyone in your family had any of the following conditions?

__Alcoholism
__Allergies
__Alzheimer's
__Anemia
__Anxiety
__Arthritis
__Asthma
__AIDS/HIV
__Bleeding Disorder
__Blood Disorder
__Cancer
__Depression
__Diabetes
__Epilepsy
__Genetic Disorder
__Glaucoma
__Heart Disease
__Hepatitis
__High Cholesterol
__High Blood Pressure
__Joint Disorder
__Kidney Disease
__Liver Disorder
__Lung Disease
__Migraines
__Psychiatric Disorders
__Osteoporosis
__Stroke
__Substance Abuse
__Thyroid Disorder

Details of family history:

_____

_____

Health Exams & Procedures

Please date the last time you had each exam or procedure done:

Yearly Physical	Colonoscopy	Mammogram	Pap Smear
Prostate Cancer Screening (PSA)	Blood Pressure Check	Cholesterol Screening	Diabetes Screening (A1C)
Osteoporosis/Bone Density	Abdominal Aortic Aneurysm	Vision and Hearing Screening	Depression Screening

Immunizations

Please indicate if you have received the following immunizations:

Hepatitis A	Hepatitis B	HPV Vaccination	Influenza (Flu Shot)	Meningitis
Measles, Mumps, Rubella (MMR)	Pneumonia	Polio	Tetanus	Acellular Pertussis (Whooping Cough)

Do you experience any of the following symptoms?

General

__Chills
__Dizziness
__Fainting
__Fever
__Hair Loss
__Hair Growth
__Night Sweats
__Sleeping Problems
__Excessive thirst
__Weight Gain
__Weight Loss

Gastrointestinal

__Appetite Gain
__Appetite Loss

ENT

__Bleeding Gums
__Blurred Vision
__Crossed Eyes
__Difficulty Swallowing
__Double Vision
__Earaches
__Ear Discharge
__Hay Fever
__Hoarseness
__Hearing Loss
__Nose-Bleeds
__Persistent Cough
__Recurring Sore Throat
__Sinus Problems
__Vision Halos

Patient Name:_____ Date of Appointment:_____

Gastrointestinal Contd
__Bloating
__Bowel Changes
__Constipation
__Diarrhea
__Gas
__Hemorrhoids
__Indigestion
__Intesinal Disorder
__Lactose Intolerant
__Nausea
__Rectal Bleeding
__Stomac Pain
__Vomiting
__Vomiting Blood

Mental Health
__Anxiety
__Depression
__Loss of Interest
__Feeling of Hopeless
__Hearing Voices
__Marital Problems
__Panic Attacks
__Trouble Concentrating
__Suicide thought/attempts

Skin
__Acne
__Bruise Easily
__Changes in Moles
__Dry/Sensitive Skin
__Cold Skin
__Eczema
__Hives
__Itching
__Rash
__Scars
__Sores that won't heal

Genitourinary
__Blood in Urine
__Lack of Bladder Control
__Frequent Urination
__Painful Urination

Neurological
__Coordination Problems
__Convulsions
__Difficulty Walking
__Learning Disabilities
__Light-Headedness
__Memory Loss
__Numbness/Tingling
__Paralysis
__Seizures
__Speech Problems
__Tremors

ENT Cont
__Ringing in Ears
__Persistent Runny Nose

Respiratory
__Coughing
__Coughing up blood
__Shortness of Breath
__Wheezing

Cardiovascular
__Chest Pain
__Irregular Heartbeat
__Circulation Problems
__Heart Palpitations
__Rapid Heartbeat
__Swelling of Ankles
__Varicose Veins

Musculoskeletal
__Back Pain
__Carpal Tunnel Syndrome
__Joint Pain
__Neck Pain
__Shoulder Pain
__Joint Swelling

Men Only
__Erection Difficulties
__Lump in testicles
__Penile Discharge
__Sore on penis

Women Only
__Abnormal Pap Smear
__Bleeding Between Periods
__Breast Lump
__Extreme Menstrual Pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Vaginal Discharge

Patient Name:_____ Date of Appointment:_____

NP HAGANS WALK-IN CLINIC
CONSENT TO TREAT AND RELEASE OF INFORMATION
Health Insurance Portability & Accountability Act (HIPPA) of 1996 REQUIREMENT

The undersigned authorizes NP Hagans Walk-In Clinic to furnish medical treatment and the performance of those procedures which are considered necessary and proper in the treatment of the patient identified on this form. I hereby authorize NP Hagans Walk-In Clinic to furnish all my insurance companies, and my employer, any information which they may request, including photocopies from my medical records as necessary for completion of my claim, or as may be required by law for this treatment. I further authorize NP Hagans Walk-In Clinic to furnish information from my medical records pertaining to this treatment as requested by other physicians or medical care facilities such as, extended care facilities, intermediate care facilities, hospitals, or home health agencies for my continued care and treatment.

I,_____, authorize NP Hagans Walk-In Clinic to release my medical information for my treatment to the additional person(s) below:

_____ _____
Name Relation

_____ _____
Name Relation

_____ _____
Name Relation

For the specific types of communications listed below, circle the YES or NO to indicate which you give us permission to use:

1. YES NO Leave messages/results for you on an answering machine at home.
2. YES NO Leave messages/results with specific family member_____(family member name/relation)
3. YES NO Leave messages/results on your private voice mail at work.
4. YES NO Leave messages/results on your cell phone voice mail

I understand that the medical records to be released may contain all of my current and past medical history, diagnoses, and treatments. In addition, information related to HIV/AIDS status, sexually transmitted diseases, alcohol or drug use, or mental health services and I hereby authorize the release of this information.

This consent is valid for the date signed until revoked in writing by the patient.

_____ _____
Patient or Guardian Signature Date