



NORTH PROVIDENCE PRIMARY CARE

Welcome to our facility. To better serve you, we ask for your cooperation in completing the following form:

Name: _____ Today's Date: _____
Date of Birth: _____ SSN: _____
Street Address: _____ Name of Employer: _____
City, State & Zip Code: _____ Occupation: _____
Home Telephone #: _____ Cell/Work Phone #: _____
Email Address: _____
Emergency Contact: _____ Telephone #: _____
Health Insurance Carrier: _____ Policy #: _____
Who referred you? _____
Name & Address of Subspecialty Physicians that care for you: _____
Pharmacy Name: _____ Pharmacy #: _____

Please list your problem/complaint/reason for visit: _____

When did it begin: _____ Is this complaint work related [] Yes [] No Has it been reported? [] Yes [] No
When did it occur? _____
If work related, describe events: _____
Current Medications: _____

Do you have any allergies? [] Yes [] No If so, please explain: _____

Medical History (circle any that apply)

- Anxiety Colitis Gallstones Irregular Heart Beat Prostate Disease
Asthma Depression Glaucoma Kidney disease/stones Stroke
Anemia/blood disorder Diabetes Heart Attack Liver disease/hepatitis Thyroid disorder
Blood clots Dementia Heart Failure Migraine headaches Tuberculosis
Cancer Eczema Hypertension Osteoporosis Ulcer
Cataracts Emphysema High Cholesterol Peripheral Vascular Disease Other: _____

List any surgical procedures you have had: _____

Do you smoke? [] Yes [] No How many packs per day? _____ For how long? _____
Do you drink alcohol? [] Yes [] No How many drinks per week? _____

Sexual History:

Are you currently sexually active? [] Yes [] No Do you practice "safe sex" (sexually monogamous, condom use)? [] Yes [] No
Are you heterosexual or homosexual? _____
Have you ever contracted a sexually transmitted disease (circle all that apply)
Gonorrhea Herpes Pelvic Inflammatory Disease Chlamydia Condyloma (genital warts)
Syphyllis Trichomonas Gardnarella (bacterial vaginosis) HIV Other: _____
Would you like to be tested for HIV? [] Yes [] No

Gynecological History (Women Only):

Date of Last PAP/Gynecology exam: _____ Date of last mammogram: _____
Gynecologist: _____ Date of last Bone Density Test: _____
Menstrual History: Onset (age) _____ Menopause (age) _____ Do you use oral contraceptives? [] Yes [] No
Number of pregnancies: ___ ([] Vaginal Delivery or [] C-Section) Number of miscarriages: ___ Number of Abortions: ___

(Please complete second page)

Immunization History:

Have you ever been immunized for the following? Check if yes, and include dates:

<input type="checkbox"/> Tetanus	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Pertussis	_____	<input type="checkbox"/> Annual Flu vaccine	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Meningitis	_____

Trauma History:

Have you ever been injured in an accident? Yes No

If yes, what injuries did you sustain & when: _____

Did this result in any permanent disability? Yes No

Family History (circle and specify relationship of any family members medical conditions)

Alcoholism	_____	Ovarian cancer	_____	Hepatitis	_____
Asthma	_____	Diabetes	_____	Kidney disease	_____
Blood disorders	_____	Heart Disease	_____	Dementia	_____
Breast cancer	_____	High cholesterol	_____	Mental illness	_____
Colon cancer	_____	High blood pressure	_____	Tuberculosis	_____

Have you had any recent episodes of the following? (circle any that apply)

Fever/chills	Swollen glands	Diarrhea	Urinary incontinence	Anxiety
Night sweats	Chest pain/pressure	Constipation	Sexual dysfunction	Depression
Sore throat	Pain with breathing	Blood in stool	Waking up to urinate	Insomnia
Problems swallowing	Rib pain	Urinary frequency	Back pain/spasm	Cold/heat intolerance
Ear pain	Cough	Blood in urine	Numbness	Seizures
Tinnitus/hearing loss	Wheeze	Irregular periods	Weakness	Rash
Sinus pressure	Bloody sputum	Heavy periods	Joint pain/swelling	Heartburn
Neck pain	Abdominal pain	Difficulty w/ urination	Impaired mobility	Palpitations
Other: (please describe) _____				

Health Screening:

For women: Do you perform self breast exams? Yes No
 Do you take calcium supplements? Yes No

For men: Do you perform self testicular exams? Yes No

Have you ever had a colonoscopy? Yes No If yes, date of exam: _____ GI Doctor: _____

Do you observe a low fat/low cholesterol diet? Yes No Do you take fiber supplements? Yes No _____

Have you had a dilated eye exam in the past 2 years? Yes No If yes, when was this done? _____

For Diabetics: Name of Podiatrist: _____ Name of Ophthalmologist: _____
 Date of last exam: _____ Date of last exam: _____
 Glucometer monitoring? Yes No Adherence to diabetic diet? Yes No

Safety Assessment:

Do you wear a seatbelt? Yes No
 Do you have a smoke detector/carbon monoxide detector in your home? Yes No
 Do you wear a helmet when you ride a bike? Yes No

Health Directives:

Have you designated anyone to function as your legal guardian or decision maker (by completing a "Living Will" or Durable Power of Attorney" form) in the event that you are unable to make decisions regarding your health care? Yes No

If yes, please list that individual: _____ Telephone No: _____
 Address: _____ Relationship to you: _____

Have you made decisions regarding the use of life sustaining measures if the need should arise (i.e. CPR/electric shock, feeding tubes, hydration)? Yes No If yes, please describe: _____

Patient Signature: _____ **Date Signed:** _____

Reviewed by: Physician/PA Signature _____