MEDI CLINICS
PRIMARY CARE

PERSONAL HISTORY & HEALTH ASSESSMENT

**INFO MUST BE FILLED OUT

GENERAL INFORMATION

PATIENTS NAME_____ SOCIAL SECURITY_____

DATE OF BIRTH____/____/_____ SEX M/F PHONE (___) _____CELL (____) _____

ADDRESS_____CITY_____ STATE_____ ZIP_____

EMAIL ADDRESS_____PREFERRED METHOD OF CONTACT E / P / C

**DO YOU HAVE INSURANCE? Y/N PRIMARY _____ SECONDARY_____

DO YOU HAVE A LIVING WILL OR MEDICAL ADVANCE DIRECTIVE? Y / N

PREFERRED LANGUAGE:_____ ETHNICITY:_____

EMPLOYER_____ PHONE (_____) _____

**EMERGENCY CONTACT_____RELATIONSHIP_____PHONE _____

**PREFERERRED PHARMACY_____ PHONE _____

PAST HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSESS? *(PLEASE CIRCLE ALL THAT APPLY)*

ANEMIA	GOUT	SEASONAL ALLERGIES
HYPOTHYROID	BACK PAIN	PSYCHIATRY HISTORY
PNEUMONIA	KIDNEY DISEASE	ARTHRITIS
CHICKEN POX	COLITIS	HYPERTHYROID
SLEEP APNEA	NERVOUS BREAKDOWN	CONGESTIVE HEART FAILURE
HIGH BLOOD PRESSURE	STD	SKIN CONDITIONS
URINE INFECTION	DIABETES	HIV/AIDS
ASTHMA	THYROID DISEASE	
MEASLES	HEPATITIS- A, B, or C	

HAVE YOU EVER BEEN HOSPITALIZED IN THE PAST FOR? **CIRCLE ALL THAT APPLY**

HEART ATTACK- Y / N

IF YES, WHEN? _____ STENTS_____ BYPASS_____

DIABETES- Y / N

IF YES, TAKING INSULIN- Y /N HOW MANY TIMES DO YOU CHECK BLOOD SUGAR? _____

CANCER- Y / N

IF YES, CHEMO_____RADIATION_____REMISSION_____

LUNG DISEASE/PNEUMONIA, RENAL FAILURE/KIDNEY DISEASE, EMPHYSEMA, COPD, ASTHMA

IF YES, DIALYSIS OR HOME OXYGEN_____

PSYCHIATRICT HX- Y / N

DEPRESSION, SUCIDIAL, ANXIETY, ADD/ADHD, AND/OR BIPOLAR DISORDER

HOSPITALIZATIONS

_____

_____

CURRENT MEDICATIONS (INCLUDE VITAMINS)

1._____ 7._____

2._____ 8._____

3._____ 9._____

4._____ 10._____

5._____ 11._____

6._____ 12._____

ALLERGIES (MEDICATIONS, FOOD, OTHER)

_____

_____

PERSONAL HABITS

DO YOU SMOKE ? Y/N

IF YES, HOW MANY PACKS PER DAY_____ HOW MANYYEARS_____

ANY PAST HISTORY OF SMOKING? Y/N

IF YES, WHEN DID YOU QUIT?_____

TOBACCO USE? Y/N

DO YOU DRINK ALCOHOL? Y/N

IF YES, WHAT TYPE?_____ HOW MANY YEARS_____

ANY HISTORY OF SUBSTANCE USE INCLUDING MARIJUANA/ LSD / HEROIN / COCAINE / SPEED / OTHER

_____

SOCIAL HISTORY

MARRIED ? Y/N

CHILDREN? Y/N

IF YES, HOW MANY?_____

DISABLED? Y/N

IF YES, WHY?_____

HOW MANY YEARS?_____

FAMILY HISTORY

HAS ANY OF YOUR FAMILY HAD ANY OF THE FOLLOWING ILLNESSES? IF YES, WHOM?

___ CANCER _____ ___ CORONARY ARTERY DISEASE _____

___ DIABETES _____ ___ HYPERTENSION _____

ANY OTHER_____

I verify that both of the pages of this form have been filled out to the best of my knowledge. I authorize medical services to be rendered to me by Medi Clinics Primary Care LLC. I authorize that payment of authorized medical benefits including supplemental be made on my behalf for any services furnished by Medi Clinics Primary Care LLC. I also authorize billing of claims to my insurance carrier and that payment is made to Medi Clinics Primary Care LLC. I understand that any unpaid balance not covered by my insurance carrier will be payable by "me." The account is considered in default if balance is pending for more than sixty (60) days. In the event of default on my account, I understand and agree that I am legally liable for 18% APR and all costs of collection to this debt. Medi Clinics Primary Care LLC may retain a collection agency to handle delinquent accounts. All necessary legal action will be taken to collect this debt if default occurs. All delinquent accounts will be reported to credit bureaus.

SIGNATURE_____DATE_____