Centura Health Physician Group

Centura Health

Patient Information
PG-2000 rev. 03/17

Complete New Patient Paperwork Online! Visit epic.mycenturahealth.org to complete your Health History Questionnaire and update your information.

PATIENT INFORMATION

Name: _____ SSN: _____
Last First MI

Sex: ☐ M ☐ F DOB: _____ Preferred Name: _____

Address: _____

_____
City State Zip

Mailing address: ☐ Check if same as above

_____
Address

_____
City State Zip

Home Phone: _____ Cell: _____

Email: _____

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed ☐ Declined

Would you prefer to speak to your healthcare provider through a translator? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Other (please specify): _____ Written Language: _____

Religion: _____ ☐ Declined Birthplace: _____

Ethnicity: Do you consider yourself to be Hispanic or Latino? ☐ Yes ☐ No ☐ Declined

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ White
☐ Black or African American ☐ Asian ☐ Declined

Employer: _____ Employer Phone: _____ Occupation: _____

Status: ☐ Part-time ☐ Full-time ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Disabled ☐ Student
☐ Unemployed

PHARMACY	**Address/Cross Streets**	**Phone Number**	**Preferred**
Local: _____	_____	_____	☐
Alternative: _____	_____	_____	☐
Mail Order: _____	_____	_____	☐

CARE TEAM

Primary Care Provider: _____ Phone Number: _____

Specialist Name: _____ Specialty: _____ Phone Number: _____

Specialist Name: _____ Specialty: _____ Phone Number: _____

EMERGENCY CONTACT

Name: _____ Relation to patient: _____
Last First

Address: _____

Phone: _____

Name: _____ Relation to patient: _____
Last First

Address: _____

Phone: _____

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PARTY RESPONSIBLE FOR PAYMENT ☐ Check if same as patient

Name: _____ DOB: _____
Last First mm/dd/yy

Address: _____

_____
City State Zip

Phone: _____

SSN: _____ Relation to patient: _____

Employer: _____

Advance Directive

Do you have a Living Will / DNR? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No

If yes: _____
Please Print Name Phone Number

Would you like information regarding Advance Directive? ☐ Yes ☐ No

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Chief Complaint (Reason for Visit): _____

ALLERGIES ☐ No Known Drug Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other (latex, adhesive, food, environment): _____

Other (latex, adhesive, food, environment): _____

MEDICATIONS ☐ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

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PERSONAL MEDICAL HISTORY

Please check all diagnoses that apply to you and add notes as needed.

AIDS	☐ Yes ☐ No	Hepatitis - Type: _____	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Angina (Heart pain)	☐ Yes ☐ No	Hyperlipidemia (High cholesterol)	☐ Yes ☐ No
Arrhythmia/Palpitations	☐ Yes ☐ No	Hypertension (High blood pressure)	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Irritable Bowel Syndrome (IBS)	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No	Long-Term Steroid Use	☐ Yes ☐ No
Bleeding disorder/tendency	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	MI (Heart attack) - Date: _____	☐ Yes ☐ No
Bone Loss - DEXA: _____ Date	☐ Yes ☐ No	Motor Vehicle Accident	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Oxygen Use	☐ Yes ☐ No
Chronic Fatigue	☐ Yes ☐ No	Peripheral Artery Disease	☐ Yes ☐ No
Chronic Kidney Disease	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Chronic Pain	☐ Yes ☐ No	Restless Leg Syndrome	☐ Yes ☐ No
Connective Tissue Disorder	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
COPD/Emphysema	☐ Yes ☐ No	Sciatica	☐ Yes ☐ No
CVA/Stroke	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Diabetes - Type:	☐ Yes ☐ No	Seasonal Allergies: _____	☐ Yes ☐ No
Dialysis (hemodialysis or peritoneal)	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Disabilities: _____	☐ Yes ☐ No	Sinusitis, recurrent	☐ Yes ☐ No
Diverticulitis	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Ear Infection, recurrent	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Environmental/Food Allergies: _____	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	UTI (Bladder infections)	☐ Yes ☐ No
Genetic/Congenital Condition: _____	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No
GERD (Heartburn)	☐ Yes ☐ No	Other Conditions: _____	
GI Bleeding	☐ Yes ☐ No	_____	
Glaucoma	☐ Yes ☐ No	_____	
Gunshot Wound	☐ Yes ☐ No	Date of last dental exam: _____	
Head Injury/Concussion	☐ Yes ☐ No	Date of last eye exam: _____	
Hearing Deficit	☐ Yes ☐ No	**Date of last colonoscopy:** _____	
Heart Disease	☐ Yes ☐ No	Doctor: _____	
Heart Failure	☐ Yes ☐ No	History of colon polyps	☐ Yes ☐ No

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SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed.

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

Have you ever had a reaction to general anesthesia? ☐ Yes ☐ No

Additional Personal Medical History

_____

_____

_____

FEMALE PATIENTS ONLY

☐ Abnormal Pap smear
☐ Other GYN history (indicate below)
Age of first menstrual period: _____
Date of last menstrual period: _____
Age of menopause: _____

Form of contraception (if any): _____
Last mammogram: _____
Last Pap smear: _____
Currently pregnant? ☐ Yes ☐ No
Currently breastfeeding? ☐ Yes ☐ No

Planning pregnancy? ☐ Yes ☐ No
Number of Pregnancies: _____
Number of Deliveries: _____
Number of Elective abortions: _____
Number of Miscarriages: _____

SOCIAL HISTORY

Tobacco Use: ☐ None Quit Date: _____
☐ Pipe/Cigar ☐ Cigarettes Packs/Day: _____ Number of years smoked: _____
☐ Smokeless tobacco ☐ Electronic or E-Cigarette ☐ Secondhand smoke exposure

Alcohol Use: ☐ None ☐ Daily ☐ Occasional ☐ Trying to cut down ☐ In recovery Amount per week: _____

Drug Use: ☐ None ☐ Past Use ☐ Current
How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?
☐ None ☐ One or more
☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club
Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

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Sexual Activity: ☐ Not active ☐ Active Number of lifetime sexual partners: _____ ☐ Men ☐ Women ☐ Both
Do you have a caregiver? ☐ Yes ☐ No

Name: _____ Relationship: _____

Diet: ☐ Well Balanced ☐ Diabetic ☐ Vegetarian ☐ Fast food/Fats/Carbs
☐ Weight Loss Products _____ ☐ Vitamins/Herbs

Exercise/Activity Level: ☐ Sedentary ☐ Strength/Wt. Training ☐ Stretch/Balance
☐ Twenty minutes/day exercise ☐ Exercise three times weekly ☐ Aerobic/Cardiac

With whom do you live? ☐ Alone ☐ Children ☐ Spouse/Partner ☐ Parents ☐ Assisted Living: _____

Education: ☐ GED ☐ High School ☐ Did not complete High School ☐ College ☐ Advanced Degree ☐ Technical/Trade

Occupation: _____

Leisure activities: _____

Religion: _____

Do you: ☐ Use seatbelts ☐ Use a helmet ☐ Have guns in home ☐ Have smoke detector in home

Abuse
I feel safe at home: ☐ Yes ☐ No
Is there anyone you are afraid of? ☐ Yes ☐ No
Do you have a history of abuse? ☐ Yes ☐ No

TRAVEL
In the last 30 days, have you traveled to any foreign countries? ☐ Yes ☐ No List: _____

IMMUNIZATIONS
Please provide any known dates or full immunization record(s).

Tetanus or Tetanus/Pertussis: _____ (mm/dd/yy) Influenza: _____ (mm/dd/yy) Shingles: _____ (mm/dd/yy) Meningitis: _____ (mm/dd/yy)

Hepatitis A: _____/_____ (mm/dd/yy) (mm/dd/yy) Hepatitis B: _____/_____/_____ (mm/dd/yy) (mm/dd/yy) (mm/dd/yy)

HPV: _____/_____/_____ (mm/dd/yy) (mm/dd/yy) (mm/dd/yy) Pneumococcal 13 or 23: _____ (mm/dd/yy) Other: _____

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

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FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes below, if known.

Relationship	Name	Status	No Known Problems	Alcohol abuse	Asthma	Blood clots	Breast cancer	Colon cancer	Prostate cancer	Other cancer(s)	Dementia	Diabetes	Heart disease	High blood pressure	High cholesterol	Kidney disease	Liver disease	Lung disease	Mental Illness	Ovarian Cancer	Stroke	Thyroid condition(s)	Other:_____	Other:_____	Other:_____
Mother		☐ Alive ☐ Deceased																							
Father		☐ Alive ☐ Deceased																							
Sister		☐ Alive ☐ Deceased																							
Brother		☐ Alive ☐ Deceased																							
Son		☐ Alive ☐ Deceased																							
Daughter		☐ Alive ☐ Deceased																							
Maternal Grandmother		☐ Alive ☐ Deceased																							
Maternal Grandfather		☐ Alive ☐ Deceased																							
Paternal Grandmother		☐ Alive ☐ Deceased																							
Paternal Grandfather		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							

Are you adopted?: ☐ Yes ☐ No

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Patient Label

Review of Systems
PG-2001 rev. 03/17

Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS**:

General/ Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Diaphoresis (Sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Irritability
- ☐ Unexpected Weight Change

Ear, Nose & Throat
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia (Sensitivity to Light)
- ☐ Visual Disturbance (Blurred Vision)

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Airway Obstruction)
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations (Irregular Heart Beat)

Gastrointestinal
- ☐ Abdominal Distention (Bloating)
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Abnormal Thirst)
- ☐ Polyphagia (Abnormal Hunger)
- ☐ Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Swelling
- ☐ Myalgias (Muscle Pain)
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Pallor (Paleness)
- ☐ Rash
- ☐ Wounds

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurologic
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headache(s)
- ☐ Light Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Loss of Consciousness)
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy (Swollen Glands)
- ☐ Bruising Tendency
- ☐ Bleeding Tendency

Behavioral
- ☐ Agitation
- ☐ Behavioral Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Mood Changes)
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervousness
- ☐ Anxiety
- ☐ Self Injury
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts

Any other symptoms: _____

_____

_____ Patient or Guardian Name (please print)

_____ Patient or Guardian Signature

_____ Date