



# PUTNAM NORTH FAMILY MEDICAL

## PATIENT DEMOGRAPHICS



PATIENT NAME :		ACCT #
DATE OF BIRTH:	SS#	SEX:
HOME PHONE:	CELL PHONE:	E-MAIL ADDRESS
ADDRESS:		
PATIENT'S EMPLOYER:		WORK PHONE:
MARITAL STATUS: M   S   W   D		Spouse's Name:
SPOUSE'S WK PHONE:		NEXT OF KIN (OTHER THAN SPOUSE):
NEXT OF KIN PHONE:		RELATIONSHIP:
EMERGENCY CONTACT:		PHONE:

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN WHO PERFORMED THE MEDICAL SERVICE AND THE RELEASE OF ANY MEDICAL, PSYCHIATRIC OR OTHER INFORMATION NECESSARY TO PROCESS ALL INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED OR DEEMED NOT MEDICALLY NECESSARY BY MY INSURANCE COMPANY. A PHOTOSTAT OF THE AUTHORIZATION SIGNATURE IS AS VALID AS THE ORIGINAL. I AUTHORIZE PNFMC TO CONVERSE WITH ME VIA ELECTRONIC E-MAIL REGARDING MY MEDICAL CARE/CONDITION.

SIGNATURE: _____		DATE: _____	
PRIMARY INSURANCE:		SUBSCRIBER'S NAME:	
SUBSCRIBER'S SSN:	RELATIONSHIP TO PATIENT:	SUBSCRIBER'S DOB:	
POLICY ID / GROUP:		SUBSCRIBER'S EMPLOYER:	

LIST OTHER PERSONS COVERED:

SECONDARY INSURANCE:		SUBSCRIBER'S NAME:	
SUBSCRIBER'S SSN:	RELATIONSHIP TO PATIENT:	SUBSCRIBER'S DOB:	
POLICY ID / GROUP:		SUBSCRIBER'S EMPLOYER:	

LIST OTHER PERSONS COVERED:

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL, PSYCHIATRIC OR OTHER INFORMATION TO THE PERSON(S) LISTED BELOW: \*\*\*\*PLEASE PRINT\*\*\*\*

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

(MINORS REQUIRE SIGNATURE OF PARENT AND/OR GUARDIAN)

SIGNATURE: _____		DATE: February 24, 2005
I UNDERSTAND AND HAVE BEEN PROVIDED WITH A NOTICE OF INFORMATION PRACTICES THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. IN ADDITION, I GIVE MY PERMISSION FOR THE PUTNAM NORTH FAMILY MEDICAL CENTER TO LEAVE A MESSAGE ON MY VOICE MAIL REGARDING UPCOMING APPOINTMENTS, ETC.		
SIGNATURE: _____		DATE: _____

CKIN \_\_\_\_\_ (Employee initials)

## Putnam North Family Medical Center

Name \_\_\_\_\_

Account Number \_\_\_\_\_

	Yes	No		Yes	No
<b>Constitutional Symptoms</b>			<b>Cardiovascular</b>		
Recent weight change			Heart trouble		
Weight increased by _____ pounds since _____			Chest Pain Presently / Previously		
Weight decreased by _____ pounds since _____			Worsened with exercise?		
Fatigue Current / Previous			Mild / Moderate / Severe		
Fever			History of Angina Pectoris		
Headaches Current / Previous			Palpitations		
Frequency			Shortness of breath		
Trigger			With walking / lying flat		
Location			Swelling of feet, ankles or hands		
Medication(s) tried			Date of last stress test / EKG _____		
Visual changes			Results _____		
Severity 1 2 3 4 5 6 7 8 9 10 (circle)			<b>Respiratory</b>		
Nausea			Frequent coughing		
Vomiting			Coughing up blood Current / Previous		
Previously diagnosed as migraines			History of Asthma / COPD/ Emphysema		
<b>Eyes</b>			Currently wheezing		
Eye disease Current / Previous			<b>Gastrointestinal</b>		
Eye injury Current / Previous			Loss of appetite		
Wear glasses or contacts			Reflux or heartburn		
Blurred or double vision			Current/Previous change in bowel movements		
Is this new?			Diarrhea/blood/mucus/constipation		
Glaucoma			Nausea or vomiting		
Do you see an eye doctor every year?			Pain with bowel movements		
<b>Ears/Nose/Throat/Mouth</b>			Hemorrhoids Current / Previous		
Hearing loss New / Chronic			Abdominal pain Current / Previous		
Ringing in ears			Ulcer Disease Current / Previous		
Earaches or ear drainage			Diverticular Disease Current / Previous		
Frequent ear infections as a child			History of bowel obstruction		
Ear tube placement Current / Previous			Date of last colonoscopy _____ Results _____		
Dizziness Current / Previous			<b>Genitourinary</b>		
Allergies / Hayfever			Frequent or painful urination		
Frequent Nose Bleeds			Blood in urine Current / Previous		
Mouth Sores			Change in stream force when urinating		
Bleeding Gums			Incontinence or Dribbling		
Bad breath or bad taste in mouth			Kidney stones Current / Previous		
Sore throat			Sexual difficulty Current / Previous		
Swollen glands in neck			Medication used to treat _____		
<b>Integumentary</b>			<b>Male</b>		
Rash			Penile discharge / sores / STD		
Change in skin color			Testicular pain		
Change in hair			Prostate Infection Current / Previous		
Change in nails			Enlarged Prostate		
Varicose veins			Date of last prostate test _____ Results _____		
History of skin cancer			<b>Female</b>		
What type? _____			Pain with periods		
Treatment _____			Irregular periods		
<b>Vaccinations</b>			Vaginal discharge or sores		
Childhood vaccines complete			Vaginal infection or STD When _____		
Date of last Flu vaccine _____			Number of Pregnancies _____		
Date of last Tetanus _____			Number of miscarriages _____		
Date of last Pneumonia vaccine _____			History of abortions		
			Date of last pap _____ Result _____		
			Type of birth control used _____		

	Yes	No		Yes	No
<b>Musculoskeletal</b>			<b>Hematologic / Lymphatic</b>		
Joint pain			Wounds slow to heal		
Which joint(s) _____			Easy bleeding or bruising tendency		
Joint swelling			Anemia Current / Previous		
Which joint(s) _____			Phlebitis		
Muscle Weakness			Blood clots Current / Previous		
Back pain Current / Previous			Location _____		
Leg pain Current / Previous			Blood transfusions		
Arm pain Current / Previous			Organ transplant		
Cold extremities Current / Previous			Which organ(s) _____		
Difficulty walking Current / Previous			Enlarged lymph nodes		
<b>Breasts</b>			Location _____		
Breast pain			Blood type _____		
Breast lump			<b>Allergic / Immunologic</b>		
Breast biopsy Results			History of reaction to:		
Breast cancer Current / Previous			Penicillin or other antibiotic		
Breast discharge			Reaction _____		
Last Mammography Results			Morphine, Demerol, other narcotic		
Preform monthly breast self exams			Reaction _____		
<b>Neurological</b>			Novocain or other anesthetic		
History of seizures			Reaction _____		
Numbness or tingling sensation			Asprin or other pain medication		
Location _____			Reaction _____		
Triggers _____			Tetanus or other serums		
Tremors			Reaction _____		
Paralysis			Iodine or other antiseptic		
Stroke			Reaction _____		
Part Affected Permanent/Temporary			Latex		
Head injury Current / Previous			Reaction _____		
<b>Psychiatric</b>			Known food allergy		
Memory loss Current / Previous			Type of food _____		
Nervousness Current / Previous			Reaction _____		
Insomnia Current / Previous			Known environmental allergy		
Obsess over things Current / Previous			Trigger _____		
Compulsions Current / Previous			Reaction _____		
Difficulty falling asleep Current / Previous			<b>Specialist/concurrent physician treating patient</b>		
Awake frequently at night Current / Previous			Physician	Condition	
Require sleep every night Current / Previous			1		
Depression Current / Previous			2		
<b>Endocrine</b>			3		
Glandular hormone problem			4		
Menopause					
Thyroid Disease			<b>Current prescription / dosage / strength</b>		
Diabetes			1		
Insuline / Noninsuline / during pregnancy			2		
Excessive thirst			3		
Excessive Urination			4		
Intolerance to temperature			5		
To heat / To cold (Circle one)					
<b>Skin becoming drier</b>			<b>Current over the counter medication</b>		
Change in hat or glove size			1		
			2		
<b>Reviewed By:</b> _____			3		
<b>Date:</b> _____			4		