DMC
Medical Group

PATIENT INFORMATION

Name_____
First Middle Last

Phone Numbers: Cell_____ Home _____ Work _____

Home Address_____ City_____ Zip_____

Date of Birth _____ Social Security Number_____ Sex ◯Male ◯Female

Marital Status ◯Single ◯Married ◯Divorced ◯Widowed Race_____

Religion _____ Do you have an Advanced Directive Living Will: ◯Yes ◯ No ◯ N/A

Employer_____ Occupation_____

Primary Insurance_____ Name of Card Holder_____

Card Holders Date of Birth_____ Relationship to patient _____

Secondary Insurance_____Name of Card Holder_____

Card Holders Date of Birth_____ Relationship to patient_____

Patient Portal Available: If you want access to your PHI (personal health record) indicate your e-mail address

_____ (Example: **test@ptportal.com**)

In case of an Emergency, who can we contact _____ Relationship_____

Phone Numbers: Cell_____ Home_____ Work_____

How did you hear about our office? _____

Preferred pharmacy that you use (Name/Location/Phone number)

_____

NO ONE BUT MYSELF ◯ PLEASE CHECK IF MEDICAL CARE IS ONLY TO BE DISCUSSED WITH YOURSELF.

I AUTHORIZE THAT ALL ASPECTS OF MY MEDICAL CARE INCLUDING LAB/TEST RESULTS MAY BE DISCUSSED WITH THE FOLLOWING PEOPLE:

Name_____ Date of Birth_____ Relationship_____

Name_____ Date of Birth_____ Relationship_____

SIGNATURE OF PATIENT (PARENT/GUARDIAN)_____ **DATE**_____

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ADULT NEW PATIENT QUESTIONNAIRE

Name: _____ **Birth Date:** _____

Please list any illness or disease you have had in the past or currently have:

_____
_____
_____

Please list any surgery you have had along with the date:

_____
_____

Please list any allergies to medications you may have along with the reaction:

_____
_____

Please list your current medications along with the dose and how often you take:

_____
_____

Please list any medical service encounters you've had outside of DMC Family Health Center:

_____
_____

Do you use tobacco now? **Yes** **No** **If yes, for how long?** _____

Have you used tobacco in the past? **Yes** **No** **If yes, when did you quit?** _____

How much alcohol do you drink? (Please circle one)

None	**Minimal** (< 2 drinks on any one occasion)	**Moderate** (< 3 drinks on any one occasion)	**Heavy** (4 or more drinks on one occasion)

Please list any illness or disease in your immediate family:
Your biologic mother: _____
Your biologic father: _____
Your biologic brother: _____
Your biologic sister: _____

I certify that all the above information is accurate and to the best of my knowledge.

Patient Signature: _____ **Date**: _____

DMC Medical Group

REVIEW OF SYMPTOMS

NAME: _____

DATE: _____

The following questions will be helpful in determining any health problems you may have. Please indicate in the comments section those areas you have any concerns or problems with:

Do you have any general problems with: Comments

Loss of appetite	Night sweats
Fatigue	Weight gain
Fever	Weight loss

Do you have any problems with your skin or hair?

Dryness	New lesions/lumps
Excessive sweating	Itching
Hair growth/loss	Rash/Skin color changes
Nail changes	Changing moles

Do you have any problems with your eyes?

Color blindness	Visual disturbances
Double vision	Floaters/Flashers
Excessive tearing	Problems with bright lights
Eye pain/redness	Visual loss

Do you have any problems with your ears?

Deafness	Ear infection
Decreased hearing	Ear ache
Ear discharge	Ringing in your ear

Do you have any problems with your nose?

Runny/itchy nose	Sinus pain
Nose bleeds	Post nasal drip
Frequent colds	Chronic congestion

Do you have any problems with your mouth, throat, or neck?

Bleeding gums	Voice changes
Hoarseness	Neck mass
Oral ulcers	Neck pain/stiffness
Sore throat	Swollen glands

Do you have problems with your breathing/lungs?

Chronic cough	Shortness of breath
Cough	Coughing up blood/sputum
Decreased exercise tolerance	Wheezing

Do you have any problems with your breast?

Breast mass	Nipple discharge
Breast pain	Nipple pain
Enlarging breast	Skin changes

Do you have any problems with your heart or blood vessels?

Family history of sudden death	Heart beating too fast/slow
Chest pain/pressure	Palpitations
Swelling in your legs	Waking up short of breath
High blood pressure	Shortness of breath
Night cramps	Breathing problems if lying flat

TURN SHEET OVER – OTHER SIDE

Do you have any problems with your stomach or digestive system?

Heartburn/reflux	Food intolerance
Abdominal mass	Vomiting blood
Abdominal pain	Jaundice
Change in bowel habits	Blood in stool
Constipation/ Diarrhea	Nausea/vomiting
Dysphasia (trouble swallowing)	Bleeding from rectum

Comments:

Do you have problems with your legs or arms?

Uneven shoulders	Joint pain
Limping	Muscle twitching/atrophy
Claudicating	Muscle cramps/weakness
Decrease range of motion	Muscle aches

Do you have problems with you neurologic system?

Auras	Incoordination
Decrease memory	Loss of consciousness
Dizzy/light headedness	Seizures
Trouble speaking	Syncope
Numbness/tingling	Tremor
Headaches	Vertigo/spinning sensation
Incontinence of urine/stool	Weakness

Do you have problems with your mood?

Anxiety	Hallucinations
Change in sleep patterns	Sleeping too much
Delusions	Inability to concentrate
Depression	Insomnia
Early Awakening	Suicidal ideation
Fearfulness	Homicidal Ideation

Do you have any problems with:

Appetite changes	Sexual dysfunction
Cold/heat intolerance	Easy bruising
Change in libido	Enlarged Lymph nodes
Being overly thirsty	Spontaneous bleeding

Do you have any problem with your urinary system?

Changes in urinary stream	Blood in your urine
Painful urination	Urination at night
Frequent urination	Urinary retention
Urgent urination	Difficulty starting urine stream

Women Only- Do you experience any of the following:

Irregular periods	Heavy periods
No periods	Painful intercourse
Painful periods	Vaginal discharge/bleeding

Men Only- Do you experience any of the following?

Urethral discharge	Penile lesions
Impotence	Testicular mass/pain