| PATIENT INFORMATION & HISTORY FORM | | | | | | | | | |
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| MEDICAL ASSOCIATES OF MAQUOKETA, P.C. | | | | | | | | | |
| Name: | | | | | | | | | |
| Age: | Date of birth: | | | | | | | | SSN: |
| Current address: | | | | | | | | | |
| City: | State: | | | | | | | | ZIP Code: |
| Home Phone: | Cell Phone: | | | | | | | |  |
| Marital Status (Please circle) Married Single Widow Divorced Separated | | | | | | | | | |
| Family Physician: | | | | | | | Referred By: | | |
| Employment Information | | | | | | | | | |
| Are you employed YES NO (Please circle) | | | | | | Current employer: | | | |
| Employer address: | | | | | |  | | | |
| City: | State: | | | | | Zip Code: | | | |
| Phone: | Occupation: | | | | | | | | |
| If patient is a child, living with parent(s) | | | | | | | | | |
| Father’s Name: | | | | | | | | | |
| Address: | | | | | | | | | Phone: |
| City: | State: | | | | | | | | ZIP Code: |
| Mother’s Name | | | | | | | | |  |
| Address: | | | | | | | | | Phone: |
| City: | State: | | | | | | | | ZIP Code: |
| INSURANCE INFORMATION (we will need a copy of your insurance card) | | | | | | | | | |
| Primary Coverage Name of Carrier: | | | | | | | | | |
| Group No: | Identification No: | | | | | | | | Effective Date: |
| Secondary Coverage Name of Carrier: | | | | | | | | | |
| Group No: | Identification No: | | | | | | | | Effective Date: |
|  | | | | | | | | | |
| **LIST MEDICATIONS TO WHICH YOU ARE ALLERGIC:** | | | | | | | | |  |
| Medication: | Medication: | | | | | | | | Medication: |
| Reaction: | Reaction: | | | | | | | | Reaction: |
|  | | | | | | | | | |
| **HAVE YOU EVER BEEN HOSPITALIZED:** | | | | | | | | | |
| Reason: | Reason: | | | | | | | | Reason: |
| Year: | Year: | | | | | | | | Year: |
|  | | | | | | | | | |
| **LIST CHRONIC ILLNESSES FOR WHICH YOU ARE CURRENTLY RECEIVING TREATMENT**: None (Please circle) | | | | | | | | | |
|  | | | | |  | | | | |
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| Patient information & history form | | | | | | | | | |
| MEDICAL ASSOCIATES OF MAQUOKETA, P.C. | | | | | | | | | |
| **LIST MEDICAITONS YOU TAKE AND THE DOCTOR PRESCRIBING THE MEDICATION:** | | | | | | | | | |
| Medication: | Medication: | | | | | | | | Medication: |
| Prescribed by: | Prescribed by: | | | | | | | | Prescribed by: |
| Medication: | Medication: | | | | | | | | Medication: |
| Prescribed by: | Prescribed by: | | | | | | | | Prescribed by: |
| SURGICAL HISTORY | | | | | | | | | |
| **SURGERY** | | | | | | | | | **YEAR OF SURGERY** |
| Tonsils YES NO (Please circle) | | | | | | | | |  |
| Appendix YES NO (Please circle) | | | | | | | | |  |
| Gallbladder YES NO (Please circle) | | | | | | | | |  |
| Cancer Surgery YES NO (Please circle) | | | | | | | | |  |
| Female Surgery YES NO (Please circle) | | | | | | | | |  |
| Other: | | | | | | | | |  |
| Other: | | | | | | | | |  |
| FEMALE HISTORY | | | | | | | | | |
| Date of Last Pap: | | | Date of Last Period: | | | | | | |
| Number of Pregnancies: | | | Number of Miscarriages: | | | | | | |
| Type of Birth Control: | | | Date of Last Mammogram: | | | | | | |
| IMMUNIZATIONS | | | | | | | | | |
| Date of last Tetanus: | Date of last Pneumonia: | | | | | | | | Date of last Flu shot: |
| Have you had a Hepatitis vaccine: YES NO (Please circle) | | | | | | | | | |
| social history | | | | | | | | | |
| Do you smoke: YES NO (Please circle) | | If yes how many packs per day: | | | | | | How much alcohol do you drink: | |
| How much coffee do you drink: | | How much pop do you drink: | | | | | | Number of hours you sleep per day: | |
| Do you exercise daily: YES NO (Please circle) | | Do you have someone to help you if you are ill and need assistance: YES NO (Please circle) | | | | | | | |
| mOTHER’S FAMILY HISTORY | | | | | | | | | |
| Year of Birth: | Year of Death: | | | | | | | |  |
| List Diseases Mother had: | | | | | | | | | |
| Father’s family history | | | | | | | | | |
| Year of Birth: | | | | Year of Death: | | | | | |
| List Diseases Father had: | | | | | | | | | |
| Signatures | | | | | | | | | |
| I confirm the above information to be accurate and true to the best of my ability. | | | | | | | | | |
| Signature & Date: | | | | | | | | | Witness: |