| 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:  |