SONI
FAMILY PRACTICE, PLLC

General Information

Patient Name: _____ DOB: _____
Last First MI

Telephone Numbers: Home: _____ Cell: _____ Other:_____

Home Address: _____ City: _____ State:_____ Zip:_____

SS#: _____ - _____- _____ Male Female Single Married Divorced Widowed
(Please Circle) (Please Circle One)

Employer: _____ Main Phone Number:_____

Primary Insurance Carrier:_____ Policy ID: _____

Type of Plan: HMO PPO POS Other Insurance Carrier Phone #: (___)_____
(Please Circle One)
If Other: _____

Second Insurance Carrier: _____ Policy ID: _____

Type of Plan: HMO PPO POS Other Insurance Carrier Phone #: (___)_____
(Please Circle One)

If Other: _____

IMPORTANT: In case of emergency, who would we contact?
Name:_____ Relationship: _____
Address: _____ Phone Number: _____
Cell Phone Number: _____ Work Phone Number: _____

"I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 (thirty) days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give the medical practice (Nature Coast Primary Care) consent to perform medical treatment.

_____ Date: _____
Patient/Guardian Signature

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Health History Questionnaire

Patient Last Name:_____ Patient First Name:_____ DOB:_____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, don't answer it. Add any notes you think are important.
Main reason for today's visit: _____
Other concerns: _____

Allergies

Are you allergic to any medications: ☐ Yes ☐ No
List anything that you are allergic to (medications, food, bee stings etc.) and how each affects you.

Allergy	Reaction
1._____	_____
2._____	_____
3._____	_____

Which pharmacy do you use: _____ City: _____

Medications

Please list all the medications you are taking including inhalers, oxygen, chemotherapy, prescribed drugs, over the counter drugs and vitamins.

	Drug Name	Dosage	How Often	When Started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Immunization History

Immunizations and most recent date:

□ Chickenpox	Date: _____	□ Meningococcus	Date: _____	□Typhoid	Date:_____
□ Flu shot	Date: _____	□ MMR (Measles, Mumps, Rubella)	Date: _____	□Smallpox	Date:_____
□ Gardasil/HPV	Date: _____	□ Pneumonia	Date: _____	□Pneumococcal	Date:_____
□ Hepatitis A	Date: _____	□ Tdap (tetanus and pertussis)	Date: _____		
□ Hepatitis B	Date: _____	□ Tetanus	Date: _____		
		□ Zostavax (Shingles)	Date: _____		

Hospitalizations: (Other than operations)

Reasons	Approximate Dates
_____	_____
_____	_____
_____	_____

Serious Injuries:

Reasons	Approximate Dates
_____	_____
_____	_____
_____	_____

Past Surgical History

	Surgery	Reason	Year	Hospital
1.				
2.				
3.				
4.				

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Patient Name: _____ **Date of birth**:_____

Obstetric and Gynecological History (Women only)

Last PAP smear_____
Last mammogram_____
Age of first menstrual period_____
Date of last menstrual period or age of menopause_____
Number of pregnancies: _____ Births: _____ Living_____
Miscarriages: _____ Abortions: _____
□ Cesarean sections if yes, then number: _____
□ Bleeding between periods
□ Heavy periods
□ Extreme menstrual pain
□ Vaginal itching, burning, or discharge
□ Wake in the night to go to bathroom
□ Hot flashes
□ Breast lump or nipple discharge
□ Painful intercourse
□ Sexually active
Current sexual partner is □ Female □ Male
Do you use condoms □ Yes □ No
Other birth control methods used: _____
□ Interested in being screened for STD'S
□ Breast Self Exam

Past Medical History (Please check all that apply)

□ Alcohol Overuse
□ Amputation
□Anemia
□ Anxiety Disorder
□ Arthritis
□ Osteo □ Rheumatoid
□ Asthma
□ Bleeding Disorder (specify)_____
□ Blood Clots (or DVT)
□ Cancer (Specify)_____
□Cardiac Arrhythmias
Pacemaker _____
□ Chronic Bronchitis
□ Colitis
Specify:_____
□ COPD
□ Coronary Artery Disease
□ Claustrophobic
□ Depression
□ Diabetes – I
□ Diabetes – II
□ Insulin □ Non-Insulin
□ Dialysis
□ Emphysema
□ Falls
□ Gout
□ Heart Attack
□Other Heart Disease (CHF)
□ Hepatitis
□ Hiatal hernia or Reflux Disease
□ HIV or AIDS
□ High Cholesterol
□ High Blood Pressure
□ Kidney Disease
□ Kidney Stones
□ Leg/Foot Ulcers
□ Liver Disease (Specify):_____
□ Migraine Headache
□ Mumps
□ Nervous Breakdown
□ Neuropathy
□ Osteoporosis
□ Ostomies
□ Overactive Thyroid
□ Paralysis
□ Polio
□ Pulmonary Embolism
□ Reflux or Ulcers
□ Seizures
□ Sleep Disorder
□ Stroke
□ Tuberculosis
□ Vascular Disease
□ Other

Other conditions: _____
Have you ever had a cardiac stress test □ Yes □ No If so when:_____
Do you have a history of drug addiction □ Yes □ No

PERSONAL HABITS:

1) Have you ever smoked? Yes No If Yes, are you a regular smoker now? Yes No
Have you used chewing tobacco? Yes No If Yes, number of yrs. _____ If No, when did you quit?_____
2) Do you regularly drink alcohol? Yes No If Yes, how often:_____
3) Have you ever used any of the following? Marijuana LSD Heroin Cocaine Speed Other:_____

Family Health History

Relation	Alive?	Age	Significant Health Problems
Grandmother (Maternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Grandfather (Maternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Grandmother (Paternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Grandfather (Paternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Father	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke

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Patient Name: _____ **Date of birth**: _____

Family Health History (cont'd)

Mother	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Brother/Sister	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Brother/Sister	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Other: _____	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke

PREVENTATIVE SERVICE HISTORY

Preventive Services	Date Received	Findings and Recommendations
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening > Cholesterol > LDL > EKG	 _____ _____ _____	Hypercholesterolemia _____ Hyperlipidemia _____ Other _____ EKG Results: _____
Colorectal Cancer Screening > Flexible Sigmoidoscopy > Barium Enema > Colonoscopy (not high risk) > Fecal Occult Blood Test	 _____ _____ _____ _____	
Diabetes Screening > Hg A1C > Foot Exam > Eye Exam	 _____ _____ _____	 Cataracts: Yes No Other: _____
Glaucoma Screening		Glaucoma: Yes No
Prostate Cancer Screening > Digital Rectal Exam (DRE) > Prostate Specific Antigen Test (PSA)		

_____ _____
Patient/Guardian/Parent Signature Date

Date reviewed:_____ Physician Signature:_____