SOUTH COUNTY MEDICAL GROUP

Primary Care Westerly

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Patient Information and Insurance Form

First Name:_____ **MI:**_____ **Last Name:**_____

Preferred Name:_____ **DOB**:_____ **Sex:** Male / Female

Street Address:_____

City: _____ **State**:_____ **Zip:**_____ **Email**:_____

Home Phone: _____ **Cellphone:** _____ **Work Phone:**_____
Please circle preferred Communication: *Home Phone* *Cellphone* *Work Phone* *Email*
Occupation:_____ **Employer Phone**:_____

Race *(Please circle one):*
American Indian / Alaska Native
African American
Asian
Native Hawaiian / Pacific Islander
White / Caucasian
Other / Decline

Ethnicity *(Please circle one):*
Hispanic or Latino
Not Hispanic or Latino
Declined

Marital Status (*Please circle one*):

Single Married Divorced Widowed Other

Insurance Information
Primary Insurance Plan:_____
Policy Number:_____ Group Number (*if any*):_____
Policy Holder Name & DOB (*if different from patient*):_____

Secondary Insurance Plan:_____
Policy Number:_____ Group Number (*if any*):_____
Policy Holder Name & DOB (*if different from patient*):_____

Emergency Contact:_____ **Phone Number:**_____

Preferred Pharmacy Name:_____ **City:**_____

Name:_____ **DOB:**_____

Medical History Form

Allergies (*Please list ALL allergies*):

_____
_____
_____

Medications (*Please list ALL medications prescribed or OTC with dose and frequency*):

_____
_____
_____
_____
_____
_____
_____

*****Please bring copies of all immunization records*****

Past Medical History (*Please circle all that apply*):

Anemia
Anxiety
Bleeding / Clotting Disorder
Blood Transfusion
Cancer
Chicken Pox
Chron's Disease
Concussion
Depression
Diabetes, Type I
Diabetes, Type II
Emphysema / COPD
Epilepsy / Seizures
Fibromyalgia
Gallbladder Disease
Gastroesophageal Reflux (GERD)
Glaucoma
Gonorrhea, Chlamydia, Herpes, Other STD
Headaches
Hemorrhoids or Rectal Disease
Hepatitis
High Blood Pressure
Irritable Bowel Syndrome (IBS)
Kidney Stones / Nephritis / Kidney Disease
Lyme Disease
Macular Degeneration
Mental Illness
Migraine
Osteoarthritis
Osteoporosis
Peptic Ulcers
Pneumonia
Psoriasis
Rheumatic Fever
Rheumatoid Arthritis
Seasonal Allergies
Stroke
Systemic Lupus Erythematosus
Thyroid Disease / Hypothyroid or Hyperthyroid
Tuberculosis
Ulcerative Colitis
Other:_____
_____
_____
_____

Surgical History (*Please list all past surgeries*):_____

_____

_____

Name:_____ **DOB:**_____

Family History:

Has any of your FIRST or SECOND degree relatives been diagnosed with any of the following health conditions? If so, please specify who the relative is and if it is maternal or paternal side.

*** If history of cancer or heart disease, please indicate age when diagnosed****

Cancer:_____
Type:_____
_____
Diabetes:_____
Thyroid Disease:_____
High Cholesterol:_____
High Blood Pressure:_____

Stroke:_____
Mental Illness:_____
Alcoholism:_____
Suicide:_____
Asthma:_____
Early Death (prior to 55 years old):_____
Heart Disease:_____

Tobacco

Do you smoke? Yes:_____ No:_____
If yes, how many packs per day? _____

Other:

Do you use any illegal substances? Yes:_____ No:_____
Were you ever treated for a substance abuse problem? Yes:_____ No:_____

Alcohol

Do you drink alcohol? Yes:____ No:_____
*If yes, how frequently?*_____

Women Only:

Age at meses onset:_____
Date of last period:_____
Date of last PAP:_____
Colposcopy/Biopsy/Surgery:_____
Name of GYN:_____
Number of Pregnancies:_____
Number of Children:_____
Pregnancy Complications:_____

Men Only:

Weak Urine Stream:	Yes	No
Discharge from Penis:	Yes	No
Painful / Swollen testis:	Yes	No
Prostate Trouble:	Yes	No

Safety:

Are there guns in your home?	Yes	No
Do you wear a seatbelt?	Yes	No

Review of Symptoms (*Please circle ALL that apply within the past 6 months*)**:**

Anxiety / Nervousness	Faulty Memory	Numbness	Unexpected Weight Loss
Arthritis / Joint Pain	Fever / Chills	Poor Appetite	Unusual Fears
Black Stool	Hair / Nail Problem	Rectal Bleed	Urgent Urination
Bloody Sputum / Vomit	Headaches	Rectal Discomfort	Urination Problems
Bruise Easily	Hearing Problems	Ringing of Ears	Voice Change
Chest Pain	Heart Palpitations	Seizures	Wheezing
Cough (Unexplained)	Heartburn	Sexual Problems	Work / Family Problems
Dental / Gum Symptoms	Incontinence	Shortness of Breath	
Depression	Increased Thirst	Skin Problems	
Diarrhea	Itching	Swollen Feet	
Difficulty Swallowing	Jaundice	Swollen Glands	
Dizziness	Muscle Aches / Weakness	Throat Discomfort	
Ear Pain / Discharge	Nausea	Trouble Sleeping	
Excess Sweating	Nighttime Urination	Trouble with Vision	
Fainting	Nose Bleeds	Unexpected Weight Gain	
Fatigue			

Legal Forms:

Do you have a medical durable power of attorney?	Yes	No
Do you have an advanced directive?	Yes	No

If yes to either, please provide the office with a copy of the legal documents for our files.