

Emed Primary Care



Name (First, MI, Last): _____

Date of Birth: _____ Age: _____ Sex (M/F): _____ Social Security # _____

Marital Status: Single Married Phone Number: (Cell) _____ (Home) _____

Street Address: _____ (Apt/Lot #) _____

City: _____ State: _____ Zip: _____

1) Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone Number: _____

2) Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone Number: _____

INSURANCE INFORMATION

FOR ACCURATE BILLING, PLEASE BE SURE TO PROVIDE ALL ACTIVE INSURANCE POLICY INFORMATION, INCLUDING MEDICARE AND MEDICAID IF APPLICABLE.

	Carrier/Insurance Name	Member/Policy Number	Subscriber Information
Primary Insurance			<input type="checkbox"/> Self <input type="checkbox"/> Name: DOB:
Secondary Insurance			<input type="checkbox"/> Self <input type="checkbox"/> Name: DOB:
Tertiary Insurance			<input type="checkbox"/> Self <input type="checkbox"/> Name: DOB:

Medicare Member #: _____ Florida Medicaid Member #: _____

PAST MEDICAL HISTORY: Please check the conditions you have now or have been diagnosed with.

<input type="checkbox"/> Abuse	<input type="checkbox"/> Bleeding Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Intestinal Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Abnormal PAP	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Genetic Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Anxiety/Nerves	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraines	<input type="checkbox"/> Series Accident	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sexual Disease	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Alcoholism / Drug abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease	

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Fill out only the sections for diagnoses you currently have or have previously had.

<p>Anxiety/Depression (check all that apply)</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Agitation • <input type="checkbox"/> Feeling Overwhelmed • <input type="checkbox"/> Insomnia • <input type="checkbox"/> Palpitations • <input type="checkbox"/> Guilt • <input type="checkbox"/> Hopelessness • <input type="checkbox"/> Loss of Interest • <input type="checkbox"/> Fatigue 	<p>Arthritis</p> <ul style="list-style-type: none"> • Location: _____ • Currently on Medications? • Pain level out of 10? • Joint Pain? • Joint Swelling • Joint Weakness? • Morning Stiffness? • Fevers?
<p>Asthma</p> <ul style="list-style-type: none"> • Symptoms: • Aggravated by: • Relieved by: • (Circle one) Mild / moderate / severe • Frequency of episodes _____ • Length of time since diagnosis _____ • Currently on medications? YES or NO • (Circle one) Controlled / Uncontrolled 	<p>Allergies</p> <ul style="list-style-type: none"> • Symptoms: • Aggravated by: • Relieved by: • How long experiencing symptoms • Frequency of episodes • Currently on medications? YES or NO • (Circle one) Controlled / Uncontrolled
<p>High Cholesterol (Check any current Symptoms)</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Numbness • <input type="checkbox"/> Tingling • <input type="checkbox"/> Headache • <input type="checkbox"/> Fatigue • <input type="checkbox"/> Blurry Vision • <input type="checkbox"/> Chest Pain • <input type="checkbox"/> Shortness of Breath • <input type="checkbox"/> Ankle Swelling • <input type="checkbox"/> Dizziness 	<p>Diabetes (Check any current Symptoms)</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Type 1 or Type 2 • <input type="checkbox"/> Fatigue • <input type="checkbox"/> Frequent urination • <input type="checkbox"/> Frequently hunger • <input type="checkbox"/> Thirsty • <input type="checkbox"/> Blurry vision • <input type="checkbox"/> Dizziness • <input type="checkbox"/> Weight loss • <input type="checkbox"/> Numbness
<p>Heart Disease (Check any current Symptoms)</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Current Smoker? • <input type="checkbox"/> History of Diabetes? • <input type="checkbox"/> Dizziness • <input type="checkbox"/> Previous Stent Placement? • <input type="checkbox"/> Chest Pain? • <input type="checkbox"/> Weakness? • <input type="checkbox"/> Headache? 	<p>High Blood Pressure (Check any current Symptoms)</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Chest Pain • <input type="checkbox"/> Headache • <input type="checkbox"/> Blurred vision • <input type="checkbox"/> Dizziness • <input type="checkbox"/> Shortness of Breath
<p>Intestinal Problems (Check any current Symptoms)</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Abdominal Pain • <input type="checkbox"/> Anorexia • <input type="checkbox"/> Nausea • <input type="checkbox"/> Vomiting • <input type="checkbox"/> Diarrhea • <input type="checkbox"/> Constipation • <input type="checkbox"/> Indigestion 	<p>Hypothyroidism (Check any current Symptoms)</p> <ul style="list-style-type: none"> • Currently taking medication? YES or NO • <input type="checkbox"/> Weight gain • <input type="checkbox"/> Dry skin • <input type="checkbox"/> Constipation • <input type="checkbox"/> Cold Sensitivity • <input type="checkbox"/> Irregular Menses • <input type="checkbox"/> Depression • <input type="checkbox"/> Hair Loss

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Social History:

Tobacco Use: Never Quit Currently;

- How many cigarettes/day? _____
- How soon after waking up do you have your first cigarette? _____
- Are you ready to quit? _____

Alcohol Use: Never Quit Currently

- How often do you drink alcohol? _____

Illegal Drug Use: Never Quit Currently

Health Care Maintenance:

Screening exams: Please indicate the YEAR you last had this procedure completed

Cholesterol_____ Mammogram_____ Pap_____ Colonoscopy_____

PSA_____ DEXA Scan_____

Immunizations: Pneumonia_____ Tetanus_____ Flu Shot_____

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General

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble sleeping

Ears, Nose, Throat, Mouth

- Decreased hearing
- Tinnitus (Ringing in ears)
- Earache
- Ear Drainage
- Epistaxis (Nosebleed)
- Sinus Pain
- Sore Throat
- Hoarseness
- Thrush
- Dry Mouth
- Toothache
- Pain with Swallowing
- Stiffness
- Runny Nose

Respiratory

- Cough
- Sputum
- Wheezing
- Coughing up blood
- Shortness of breath
- Painful with breathing
- Asthma

Vascular

- Calf pain with walking
- Leg cramping

Psychiatric

- Depression
- Anxiety
- Difficulty Concentrating
- Paranoia
- Sadness
- Mania
- Altered Mental Status

Cardiovascular

- Hypertension
- Hyperlipidemia
- Chest Pain or Discomfort
- Tightness
- Palpitations
- Shortness of breath with activity
- Difficulty breathing lying down
- Swelling
- Sudden awakening from sleep with shortness of breath

Gastrointestinal

- Abdominal Pain/Cramping
- Difficulty Swallowing
- Heartburn/ Indigestion
- Change in appetite
- Black Tarry Stool
- Nausea/ Vomiting
- Diarrhea
- Vomiting Blood
- Rectal Bleeding
- Change in bowel habits
- Constipation

Genitourinary

- Urine Frequency
- Blood in Urine
- Incontinence
- Dysuria
- Nocturia
- Hematuria
- Polyuria
- Pain or Burning with Urination
- Difficulty with Erection
- Vaginal Discharge
- Vaginal Pain
- Menopause

Musculoskeletal

- Muscle or joint pain
- Stiffness
- Back pain
- Worsens with Activity
- Joint Swelling
- Decreased Range of Motion
- Arthritis
- Weakness
- Muscle Cramping

Neurologic

- Changes in Sight, Smell, Hearing, or Taste
- Headache
- Fainting
- Seizures
- Weakness
- Trouble with Balance
- Numbness/Tingling
- Tremor
- Memory Loss
- Speech Problems
- Fainting

Other
