Emed Primary Care

PATIENT LABEL

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			□ Self □ Name: DOB:
Secondary Insurance			□ Self □ Name: DOB:
Tertiary Insurance			□ Self □ Name: DOB:

Medicare Member #: _____ Florida Medicaid Member #: _____

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

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

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

Anxiety/Depression (check all that apply)	**Arthritis**
• □ Agitation • □ Feeling Overwhelmed • □ Insomnia • □ Palpitations • □ Guilt • □ Hopelessness • □ Loss of Interest • □ Fatigue	• Location: _____ • Currently on Medications? • Pain level out of 10? • Joint Pain? • Joint Swelling • Joint Weakness? • Morning Stiffness? • Fevers?
Asthma	**Allergies**
• 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	• Symptoms: • Aggravated by: • Relieved by: • How long experiencing symptoms • Frequency of episodes • Currently on medications? **YES** or **NO** • **(Circle one)** Controlled / Uncontrolled
High Cholesterol (Check any current Symptoms)	**Diabetes (Check any current Symptoms)**
• □ Numbness • □ Tingling • □ Headache • □ Fatigue • □ Blurry Vision • □ Chest Pain • □ Shortness of Breath • □ Ankle Swelling • □ Dizziness	• □ Type 1 or Type 2 • □ Fatigue • □ Frequent urination • □ Frequently hunger • □ Thirsty • □ Blurry vision • □ Dizziness • □ Weight loss • □ Numbness
Heart Disease (Check any current Symptoms)	**High Blood Pressure (Check any current Symptoms)**
• □ Current Smoker? • □ History of Diabetes? • □ Dizziness • □ Previous Stent Placement? • □ Chest Pain? • □ Weakness? • □ Headache?	• □ Chest Pain • □ Headache • □ Blurred vision • □ Dizziness • □ Shortness of Breath
Intestinal Problems (Check any current Symptoms)	**Hypothyroidism (Check any current Symptoms)**
• □ Abdominal Pain • □ Anorexia • □ Nausea • □ Vomiting • □ Diarrhea • □ Constipation • □ Indigestion	• Currently taking medication? YES or NO • □ Weight gain • □ Dry skin • □ Constipation • □ Cold Sensitivity • □ Irregular Menses • □ Depression • □ Hair Loss

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Current Medications:

Medication	Dose	Frequency	Reason

Allergies:

□ None	□ Medication_____	□Latex	□ Food
□Pollen	□Other	□Contrast Dye	

Specify any further allergies:_____

PAST SURGICAL HISTORY: Please list the year you had any of the following procedures.

_____Appendectomy _____Gallbladder _____Hernia Repair
_____Tonsillectomy _____Heart surgery/Cath _____OTHER
_____Hysterectomy _____Vasectomy _____OTHER

Hospitalizations / Major Traumas:

Date	Reason	Any Procedures Done

Family History:

Relative	Age if living	Age of Death	Major Illnesses/Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

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

_____
_____
_____
_____
_____