PATIENT INFORMATION

PATIENT:____ **DOB:**_______________________

ADDRESS ____

PHONE: (H)_________________ **(W)**____________________________ **C)**_____________________________

EMAIL: (H)____ **(W)**______________________________________

RACE / ETHNICITY: _______________________ **PREFERRED LANGUAGE:**_______________________

EMERGENCY CONTACT: ____
Name Phone

PHARMACY/DISPENSARY:____
Name Phone City/State

PRIMARY PROVIDER IN PHC: ____

PRIMARY PROVIDER OUTSIDE OF PHC: ____

SMOKING STATUS: (Please check one)

- ☐ CURRENT SMOKER
- ☐ SMOKED > 100 CIGARETTES IN MY LIFE, QUIT Date/Year_____________
- ☐ NEVER SMOKER

Over the last 2 weeks, I have had little interest or pleasure in doing things.

Circle answer: Not at All Several Days More than half the days Nearly every day

Over the last 2 weeks, I have felt down, depressed or hopeless.

Circle answer: Not at All Several Days More than half the days Nearly every day

How often have you had a drink containing alcohol in the past year?

Circle answer: Never Monthly or less 2-4 times/month 2-3 times/week 4 or more times/week

How many drinks did you have on a typical day when you were drinking in the past year?

Circle answer: 1-2 3-4 5-6 7-9 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

Circle answer: Never Monthly or less Monthly Weekly Daily or almost daily

Date/year of your last Colonscopy:___________________________________

[FEMALES]: **Date/year of your last Pap Smear**:__________________ **Mammogram** _________________________

Are you sexually active? ____

List all issues for which you are currently treated. (Please use the back of this sheet if needed)

____

List the names and specialties of all outside doctors you've seen in the last 3 years.

____

List the surgeries and any ER visits and hospitalizations you have had, give the year and location if known.

____

Are there specific reasons you don't use this health center as your Primary Doctor's Office? (All answers will be kept confidential)

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