Patient Information

Last Name: _____ First Name: _____ M.I: _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Work Phone: _____ EXT: _____ Email Address: _____

Birth Date: _____ Social Security #: _____

Gender: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐Married ☐ Single ☐ Divorced ☐ Widowed

Student : ☐ Not a student ☐ Full-time student ☐ Part-Time Student

Employer Name: _____

Employer Address: _____

Emergency Contact

Name: _____ Relation: _____
Home Phone: _____ Cell: _____ Work: _____

********If the person resides with you please give us a second contact person*******

2nd Name: _____ Relation: _____
Home Phone: _____ Cell: _____ Work: _____

Insurance

Guarantor:
Last Name: _____ First Name _____ MI: _____
Date of Birth: _____ Social Security: _____
Telephone: _____

Primary Insurance Name: _____
Address: _____
Effective Date: _____ Subscriber Number: _____
Group Number: _____

Secondary Insurance Name: _____
Address: _____
Effective Date: _____ Subscriber Number: _____
Group Number: _____

Preferred Pharmacy

Name: _____ Address/Phone : _____

Mail Order : _____ Address: _____ Phone/Fax# _____

Primary Care Physician Name : _____ Phone #: _____

Scott D. McDowall, MD

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES		Mother Father	ANEMIA		Mother Father
HIGH BLOOD PRESSURE		Mother Father	LEUKEMIA		Mother Father
STROKE		Mother Father	SICKLE CELL		Mother Father
HEART ATTACK		Mother Father	BLEEDING PROBLEMS		Mother Father
ASTHMA		Mother Father	STOMACH ULCER		Mother Father
MIGRAINE HEADACHES		Mother Father	GALLSTONES		Mother Father
CANCER		Mother Father	SEIZURES		Mother Father
EMPHYSEMA		Mother Father	TUBERCULOSIS		Mother Father
KIDNEY PROBLEMS		Mother Father	ALCOHOLISM		Mother Father
ARTHRITIS		Mother Father	SUICIDE		Mother Father
GLAUCOMA / EYE PROBLEMS		Mother Father	DEPRESSION		Mother Father
SKIN RASH		Mother Father	MENTAL ILLNESS		Mother Father
OTHER		Mother Father	OTHER		Mother Father

OPERATIONS / SURGERIES: _____

_____

Family History: _____

OTHER HOSPITALIZATIONS: _____

_____

BLOOD TRANSFUSIONS: _____

MEDICATIONS: _____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: (Any reaction to any medication of any kind?) _____

OCCUPATION / WORK HISTORY: _____

Any exposure to pesticides, chemicals, or other hazards? YES _____ NO _____

If yes, What kind? _____

Family / Household: (Who lives at home with you?)_____

_____

HABITS: Cigarettes: _____ PPD ____ X _____ years Quit in _____ (year)

Other Tobacco Products? _____ Alcohol _____

Drug Use _____ Caffeine (coffee/colas)_____

Seat Belt Use: Yes: _____ No _____ Exercise: _____

FOR WOMEN ONLY

Age of first menstrual period _____ How many days between periods? _____

How many days does it last? _____ Is bleeding heavy or light? _____

Date of last menstrual period _____ Was it normal? _____

If menstrual periods have stopped, have you had any bleeding since? _____

Any Vaginal Discharge? Yes _____ No _____ Last Pap Smear _____

Method of Preventing Pregnancy: _____

Pregnancies _____ Births _____ Abortions/Miscarriages _____

Any other concerns? _____

_____

Name:

_____

Social Security:

_____

Birth Date:

_____