Welcome. *It is our sincere desire to provide you with quality, comprehensive health care. To these ends it is important we gather a detailed picture of your health and health related issues. Please complete this form thoroughly, legibly and accurately. The final page has space for further details you wish to include. The privacy of your health information will become a legally protected part of your medical record. Thank you.*

Patient Information - ***Date:*** _____

Patient Name: _____ Date of Birth: _____ Sex:_____

Previous Last Name: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ DP

Occupation:_____ Employer: _____

Nickname: _____ Spouse Name: _____ Pronouns: _____

Parent/Legal Guardian Name: _____

State/Country of Birth: _____ Special Communication Needs: _____

Language: _____ Race: _____ Decline ☐ Ethnicity: _____ Decline ☐

Are you a Veteran? ☐ NO ☐ YES Organ Donor? ☐ NO ☐ YES Right Handed ☐ Left Handed ☐

Patient Contact Information - ***Copy of Driver's License Provided*** ☐

Address: _____ City: _____

State: _____Zip:_____County:_____Preferred Phone Number: _____

Is this phone number? ☐ Cell ☐ Home ☐ Work *May we leave detailed messages at this phone?* ☐ NO ☐ YES

Secondary Phone:_____ Email: _____

Emergency Contact Information -

Name	Relationship	Phone Number	Address

I hereby authorize ***Doylestown Healthcare Partnership*** *to discuss and or release my PHI (protected health information) to:* ***Myself Only*** ☐

Name	Relationship	Phone

Advanced Care Directive - *Do you have an Advance Directive or Living Will?* ☐ *NO* ☐ *YES*

Have you designated a Durable Power of Attorney? ☐ *NO* ☐ *YES* *If yes, please enter information below:*

Name	Relationship	Phone Number	Date

Specialist Contact Information - *(Please provide first and last names)*

	Physician Name	Office Name	Location
Cardiologist:			
Eye Doctor:			
Gynecologist:			
Endocrinologist:			
Urologist:			
Other:			

Patient Name: _____ ***Date of Birth:*** _____

Adult Vaccination/Immunization History - *(If available please attach childhood immunizations separately)*

	Date		Date		Date
Tetanus		Zoster		Prevnar 13	
TDAP		Shingrix		Pneumovax 23	

Health History - *Have you ever been diagnosed with any of the following:* ***Reconciled*** ☐

☐ Measles/ Mumps	☐ Gout	☐ Seizures / Epilepsy	☐ Bone/Joint Disorder	☐ Pneumonia
☐ Chicken Pox	☐ Stomach Ulcer	☐ Parkinson's Disease	☐ Eye Disease	☐ Asthma
☐ Rheumatic Fever	☐ Reflux Disease	☐ Multiple Sclerosis	☐ Glaucoma	☐ Seasonal Allergies
☐ Scarlet Fever	☐ Gall Bladder	☐ High Blood Pressure	☐ Kidney Disease	☐ Emphysema / COPD
☐ Polio	☐ Pancreatitis	☐ Stroke	☐ Kidney Stone	☐ Pulmonary Clotting
☐ Lyme Disease	☐ Colitis	☐ Heart Disease / CAD	☐ Urinary Disorders	☐ Depression
☐ Tuberculosis	☐ Diverticulitis	☐ Heart Attack	☐ Erectile Dysfunction	☐ Anxiety
☐ Diabetes	☐ Irritable Bowel	☐ Heart Murmur	☐ Prostate Disease	☐ Eating Disorder
☐ Sleep Apnea	☐ Hepatitis	☐ Heart Failure	☐ Reproductive Issues	☐ Psychiatric Care
☐ Anemia	☐ Liver Disease	☐ High Cholesterol	☐ Menstrual Problems	☐ Drug Addiction
☐ Bleeding Disorder	☐ Thyroid Disorder	☐ Arthritis	☐ Vaginal Infection	☐ Alcoholism
☐ Blood Clot	☐ Migraines/Headache	☐ Osteoporosis	☐ Breast Lump	☐ Sexual Dysfunction
☐ Cancer Type:_____	☐ Autoimmune Disease Type:_____	☐ Peripheral Vascular Disease	☐ Skin Disease Type:_____	☐ STD Type:_____
Other Health Conditions:				
Blood Transfusion: ☐ NO ☐ YES If yes, date: Reason:				

FAMILY HISTORY - *Details Attached* ☐ *Adopted* ☐ ***Reconciled*** ☐

Relation	Current Age, if living	Age at Death	High Blood Pressure	Heart Disease	Stroke	Cancer	Diabetes	Glaucoma	Asthma	Seizures	Bleeding Disorder
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐
Other relative			☐	☐	☐	☐	☐	☐	☐	☐	☐

Surgical History - *None* ☐ *Details Attached* ☐ ***Reconciled*** ☐

Procedure	Date

Current Medications with Dosages - *None* ☐ *Details Attached* ☐ ***Reconciled*** ☐

Patient Name: _____ ***Date of Birth:*** _____

SOCIAL HISTORY - *Details Attached* ☐ ***Reconciled*** ☐

Tobacco Use: ☐ YES ☐ NO ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew Amount per day: _____ Number of years you have used tobacco: _____ Former tobacco user: ☐ YES ☐ NO Last tobacco use: _____	Alcohol Consumption: ☐ YES ☐ NO Number of drinks per week:_____ Preferred drink (ie: beer, wine, spirits): _____ ☐ QUIT Years quit:_____	Recreational Drug Use: ☐ YES ☐ NO Type: _____ Amount per week:_____ Last used:_____ ☐ QUIT Years quit:_____
Caffeine: ☐ YES ☐ NO # of caffeine drinks per day:_____	Regular Exercise: ☐ YES ☐ NO Type exercise:_____ How often:_____	Do you share a home with anyone else? ☐ YES ☐ NO ☐ Spouse ☐ ___ Children ☐__Friend
Are you regularly exposed to second- hand smoke or other potentially harmful substances at home or work? ☐ YES ☐ NO If so what?	Do you routinely need physical assistance with activities of daily living such as cooking, dressing, hygiene? ☐ YES ☐ NO	Are guns kept in your home: ☐ YES ☐ NO If yes is gun safety a priority at home? ☐ YES ☐ NO
Does everyone in your home receive all routinely recommended immunizations? ☐ YES ☐ NO	Is it important to you that you always wear your seatbelt? ☐ YES ☐ NO	Do you have working smoke detectors in your home? ☐ YES ☐ NO
Do you have regular problems with a lack of enough food in your home? ☐ YES ☐ NO	Do you have regular problems with transportation? ☐ YES ☐ NO	Do you have regular problems paying for housing? ☐ YES ☐ NO
Are you in an abusive relationship or afraid of physical harm from anyone you know? ☐ YES ☐ NO	Are you at risk of acquiring HIV infection or other sexually transmitted disease? ☐ YES ☐ NO	Do any members of your family have genetically linked health problems? ☐ YES ☐ NO
Do you use e-cigarettes, vape or juul? ☐ YES ☐ NO		

Allergies - *No Known Drug Allergies* ☐ *Latex: Yes* ☐ *No* ☐ ***Reconciled*** ☐

Over the past two weeks, how often have you been bothered by any of the following? *(Circle number)*

	Not at All	Several Days	Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
Feeling depressed or hopeless	0 ☐	1 ☐	2 ☐	3 ☐

Wellness Screening History

	Date	Practice/Location Performed	Result
Wellness/Routine Physical Exam			
Colon Cancer Screening			
Mammogram			
Dexa (Bone Density) Scan			
Pap Smear			
PSA			
Full Body Skin Cancer Exam			
Hepatitis C Screening			
Diabetic Eye Exam			

If 65 years or older please answer the following:

Have you felt unsteady or fallen more than once in the past year?	Yes ☐	No ☐
Can you switch a light on/off easily from your bed without fear of falling?	Yes ☐	No ☐
Are floors and walkways in your home safe and in good repair?	Yes ☐	No ☐
Is it difficult to get out of bed or off a chair or toilet without assistance?	Yes ☐	No ☐
Is the lighting in your home sufficient for you to see safely?	Yes ☐	No ☐

Patient Name: _____**Date of Birth:** _____

ADDITIONAL NOTES/DETAILS -

Reviewed by Provider: _____Date:_____