

SONORAN MEDICAL CENTERS NEW PATIENT HEALTH HISTORY

Date _____ Date of Birth: _____

Name: _____

Name you prefer to be called: _____

Race: American Indian or Alaska Native Asian
 Black or African American Native Hawaiian or
 Other Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____

Pharmacy Name: _____

Pharmacy Cross Streets _____

Pharmacy Phone Number (_____) _____

Mail Order Pharmacy Name: _____

Mail Order ID # _____

Allergies to Medications:	Reaction:

Chronic Medical Problems:	Year diagnosed:

When was your last:	Result:	Date:
Physical Exam		
Colonoscopy		
Glaucoma check		
Bone Density (DEXA)		
Mammogram (females)		
Abnormal Mammogram		
Pap Smear (females)		
Abnormal Pap Smear		

When was your last:	Date:
Influenza Vaccine (Flu)	
Pneumonia Vaccine	
Tetanus Vaccine <input type="checkbox"/> with Pertussis?	
Hepatitis A Vaccine	
Hepatitis B Vaccine	
HPV? (3 shots)	
Zoster (Shingles) Vaccine (over 60)	
Have you had the chicken pox?	

Do you have allergies? Yes No

Religious Affiliation (optional)

Do you have a religious affiliation?

_____ Do you practice your religion? Yes No

List Past Surgeries:	Year:
Any blood transfusions?	

List Past Hospitalizations:	Year:

Family History: (blood relatives only)	Relationship:	Was cause of death?
Heart Disease		
Cancer Breast		
Cancer Colon		
Cancer of Lung		
Cancer of Ovaries		
Cancer of Prostate		
Cancer of Uterus		
Stroke		
Depression		
Diabetes		
High Cholesterol or Triglycerides		
High Blood Pressure		
Thyroid Disease		
Other		

Social History: Marital Status: (S,M,D,W): _____

Occupation: _____

of Children: Sons _____ Daughters _____

Who do you live with? _____

Tobacco?	Type?	How much?	How long?
Current			
Past			
Alcohol?			
Caffeine?			
Illegal Drugs?			
IV Drugs?			

If past smoker, what age did you quit? _____

Activity level: low _____ average _____ high _____

Do you have a DNR (do not resuscitate)? _____

Do you have a living will? _____

Do you have a power of attorney? _____

Do you have a health care proxy? _____

Any tattoos? _____

If you are a patient of Dr. England, please complete Gyn Patient Health History also.

The Geriatric Mood Scale

Name: _____ Date: _____

circle yes or no to the questions below.

- | | | |
|---|-----|----|
| 1. Are you basically satisfied with your life? | yes | no |
| 2. Have you dropped many of your activities and interests? | yes | no |
| 3. Do you feel that life is empty? | yes | no |
| 4. Do you often get bored? | yes | no |
| 5. Are you in good spirits most of the time? | yes | no |
| 6. Are you afraid that something bad is going to happen to you? | yes | no |
| 7. Do you feel happy most of the time? | yes | no |
| 8. Do you often feel helpless? | yes | no |
| 9. Do you prefer to stay at home, rather than going out and doing new things? | yes | no |
| 10. Do you feel that you have more problems with memory than most? | yes | no |
| 11. Do you think it is wonderful to be alive now? | yes | no |
| 12. Do you feel pretty worthless the way you are now? | yes | no |
| 13. Do you feel full of energy? | yes | no |
| 14. Do you feel that your situation is hopeless? | yes | no |
| 15. Do you think that most people are better off than you are? | yes | no |

Comments:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
 Phone: _____ Address: _____
 City: _____ State: _____ Zip Code: _____

I hereby authorize

Name of facility: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ Phone: _____ Fax: _____

to disclose the following Protected Health Information pertaining to the patient listed above to Sonoran Medical Centers.

Options below must be completed in order to release records.

For the Following Purpose:

- New Primary Care Physician
- Personal Records
- Consultation with Specialist
- Insurance Company
- Other (Specify) _____
- Other (Specify) _____

Information to be Released:

- All Records
- Records from _____ to _____
- Office Note
- Radiology Report Lab result
- Billing Statements

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that Sonoran Medical Centers will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that the above-named facility has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mailing address listed above. I understand the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives this information.

I understand that this authorization will expire one (1) year from date of signing unless specified below.

Desired Expiration Date _____

Signature

Date

Print Name

Relationship to Patient (if not patient)