SONORAN MEDICAL CENTERS NEW PATIENT HEALTH HISTORY

Date_____ Date of Birth: _____
Name: _____
Name you prefer to be called: _____
Preferred Language: _____

Pharmacy Name: _____
Pharmacy Cross Streets: _____
Pharmacy Phone Number (_____)_____
Mail Order Pharmacy Name: _____

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 □ with Pertussis?	
Hepatitis A Vaccine	
Hepatitis B Vaccine	
HPV (Gardasil) (2-3 shots)	
Zoster (Shingles) Vaccine (over 50)	
Have you had the chicken pox?	

List Past Surgeries:	**Year:**
Any blood transfusions?	

List Past Hospitalizations:	**Year:**

Family History: (blood relatives only)	**Was cause of death?**	**Relationship to you?**
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? _____

	How much?	**How often? (day/wk/mo)**	**Age Start - Stop**
Cigarette?			-
Cigarette- If restarted			-
Cigar?			-
Chew?			-
Pipe?			-
Vape?			-
Marijuana?			-
Alcohol? **Type:**			-
Caffeine?			-
Illegal Drugs?			-
Other?			-

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?_____

Religious Affiliation (optional)
Do you have a religious affiliation?_____
Do you practice your religion? Yes No
If you are a patient of Dr. Belen, please complete Gyn Patient Health History also.

Sonoran Medical Centers
19875 N. 51st Avenue
Glendale, AZ 85308
Phone: (623) 581-8998
Fax: (623) 581-6461

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
☐ FMLA/Disability
☐ Other (Specify) _____
☐ Other (Specify) _____

Information to be Released:
☐ All Records
☐ Records from _____ to_____
☐ Office Note
☐ Radiology Report ☐ Lab result
☐ Other
☐ Billing Statements
☐ FMLA/Disability Forms (please mark above if records to be released also)

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)**

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:

Sonoran Medical Centers

Patient Medication, Vitamin and Supplement Log

for (name) _____ DOB: _____ Today's Date: _____

Include prescription medications, over-the-counter medications, vitamins and herbal supplements

Pharmacy Name: _____ Phone: _____ Pharmacy Cross Streets: _____

Mail Order Pharmacy Name: _____ Mail Order ID #: _____

Start Date	Name of Medicine Brand Name/Generic Name	Dose (mg, units)	# taken per day	When do you take it? Morning/night, after meals	With food? Y or N	What's it for? Purpose	Size/color/ shape	Prescribed by Provider's name	Local Pharm or Mail order	Important Comments (danger signs, side effects, interactions)

Please bring this updated form with you to all of your medical office visits. If your medicines change, please tell your medical provider.
Check the detailed drug sheets provided by the pharmacy with each medication, or talk to your doctor about possible side effects, danger signs and interactions.

Allergies to: _____

Other Medical Providers that you are seeing (please include dentist and eye doctor):

Last Seen	Provider name	Specialty	Problem they are treating	Comments