

## 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)		
<b>Abnormal</b> Mammogram		
Pap Smear (females)		
<b>Abnormal</b> 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 (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
<b>Cigarette?</b>			-
Cigarette- If restarted			-
<b>Cigar?</b>			-
<b>Chew?</b>			-
<b>Pipe?</b>			-
<b>Vape?</b>			-
<b>Marijuana?</b>			-
<b>Alcohol?</b> Type:			-
<b>Caffeine?</b>			-
<b>Illegal Drugs?</b>			-
<b>Other?</b>			-

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:

- checkbox New Primary Care Physician
checkbox Personal Records
checkbox Consultation with Specialist
checkbox Insurance Company
checkbox FMLA/Disability
checkbox Other (Specify) \_\_\_\_\_
checkbox Other (Specify) \_\_\_\_\_

Information to be Released:

- checkbox All Records
checkbox Records from \_\_\_\_\_ to \_\_\_\_\_
checkbox Office Note
checkbox Radiology Report checkbox Lab result
checkbox Other
checkbox Billing Statements
checkbox 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) \_\_\_\_\_

