Centura Health Physician Group

Centura Health

Patient Information
PG-2000 rev. 10/18

Complete New Patient Paperwork Online! Visit epic.mycenturahealth.org to complete your Health History Questionnaire and update your information.

If you have already completed your demographics, please proceed to page 3-6 to complete your new patient paperwork if you have not already online.

PATIENT INFORMATION

Name:_____ SSN: _____
Last First MI

Sex: ☐ M ☐ F DOB:_____ Preferred Name: _____

Address:_____

_____
City State Zip

Mailing address: ☐ Check if same as above

_____
Address

_____
City State Zip

Home Phone:_____ Cell:_____

Email:_____

Marital Status: ☐Divorced ☐Legally Separated ☐Married ☐Significant Other ☐Single ☐Widowed ☐Declined

Would you prefer to speak to your healthcare provider using a translator? ☐Yes ☐No

Preferred Language: ☐ English ☐ Other (please specify):_____ Written Language: _____

Religion:_____ ☐Declined Birthplace: _____

Ethnicity: Do you consider yourself to be Hispanic or Latino? ☐Yes ☐No ☐Declined

Race:
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Filipino
- ☐ Korean
- ☐ Other Asian
- ☐ Unknown
- ☐ Asian
- ☐ Chinese
- ☐ Guamanian or Chamorro Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Decline to Answer
- ☐ Japanese
- ☐ Other
- ☐ Samoan
- ☐ White or Caucasian

Military Status: ☐Active Duty Military ☐Reserve (Active/Inactive) ☐None ☐Unknown ☐Veteran

Employer:_____ Employer Phone:_____ Occupation:_____

Status: ☐ Part-time ☐ Full-time ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Disabled ☐ Student ☐ Unemployed

PHARMACY	**Address/Cross Streets**	**Phone Number**	**Preferred**
Local:_____	_____		☐
Alternative:_____	_____	_____	☐
Mail Order:_____	_____	_____	☐

CARE TEAM

Primary Care Provider:_____ Phone Number: _____

Specialist Name:_____ Specialty:_____ Phone Number: _____

Specialist Name:_____ Specialty:_____ Phone Number: _____

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EMERGENCY CONTACT

Name:_____ Relation to patient: _____
Last First

Address:_____

Phone: _____

Name:_____ Relation to patient: _____
Last First

Address:_____

Phone: _____

PARTY RESPONSIBLE FOR PAYMENT ☐ Check if same as patient

Name:_____ DOB:_____
Last First mm/dd/yy

Address:_____

_____
City State Zip

Phone: _____

SSN:_____ Relation to patient:_____

Employer: _____

Advance Directive

Do you have a Living Will / DNR? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No

If yes:_____
Please Print Name Phone Number

Would you like information regarding Advance Directive? ☐ Yes ☐ No

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Chief Complaint (Reason for Visit): _____

ALLERGIES ☐ No Known Drug Allergies

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Other (latex, adhesive, food, environment): _____
Other (latex, adhesive, food, environment): _____

MEDICATIONS ☐ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

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PATIENT INFORMATION

Name:_____ DOB:_____
Last First MI

PAST MEDICAL HISTORY (Please check all diagnoses that apply to you and add notes as needed)
☐ None

☐ AIDS
☐ Anemia
☐ Angina (Heart Pain)
☐ Arrhythmia / Palpitations
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bleeding disorder
☐ Blood Clot
☐ Blood Transfusion
☐ Bone Loss
☐ Cataracts
☐ Chronic Fatigue
☐ Chronic Kidney Disorder
☐ COPD / Emphysema
☐ CVA / Stroke
☐ Diabetes - Type:
☐ Dialysis – Type:
☐ Disabilities – Type:
☐ Diverticulitis
☐ Ear Infection, recurrent
☐ Environmental/Food Allergies
☐ Fibromyalgia
☐ Genetic/Congenital Condition
☐ GERD (Heartburn)
☐ GI Bleed
☐ Glaucoma
☐ Gunshot Wound
☐ Head Injury / Concussion
☐ Hearing Loss
☐ Heart Disease
☐ Heart Failure
☐ Hepatitis – Type:
☐ HIV
☐ High Cholesterol
☐ High Blood Pressure
☐ Irritable Bowel Syndrome
☐ Kidney Stone
☐ Long-term Steroid Use
☐ Lupus
☐ Macular Degeneration
☐ MI (Heart Attack) – Date:
☐ Motor Vehicle Accident
☐ Oxygen use
☐ Peripheral Artery Disease
☐ Pneumonia
☐ Restless Leg Syndrome
☐ Rheumatoid Arthritis
☐ Sciatica
☐ Scoliosis
☐ Seasonal Allergies
☐ Seizures
☐ Sinusitis, recurrent
☐ Sleep Apnea
☐ Thyroid Disorder
☐ Tuberculosis
☐ UTI (bladder infection)
☐ Vertigo

ADDITIONAL PAST MEDICAL HISTORY

_____
_____
_____

SURGICAL HISTORY (Please list surgeries and add any notes as needed)
☐ None

Year	Surgery / Procedure	Hospital / Location	Complications/ Comments

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PATIENT INFORMATION

Name:_____ DOB:_____

FEMALE PATIENTS ONLY

Currently Pregnant: ☐ Yes ☐ No
Currently Breastfeeding: ☐ Yes ☐ No
Age at first Period:_____
Age at menopause: _____
Date of first day of Last Menstrual Period: _____

PREVENTIVE HEALTH SCREENINGS (Please list date of last testing and results/ additional notes)

Test	Date	Result/Notes
Bone Density (DEXA)		
Cervical Cancer Screening (Pap Testing)		
Colon Cancer Screening		
Type: ☐ Colonoscopy ☐FIT ☐FOBT ☐Sigmoidoscopy		
Mammography		
Lung Cancer Screening		
AAA Screening		
Hepatitis C Screening		

VACCINE HISTORY: (please provide any known vaccines and dates)

Immunization Name	Date(s)(mm/dd/yyyy)
Influenza	
Tetanus with Pertussis	
Tetanus	
Shingles	
Meningitis	
Hepatitis A	
Hepatitis B	
HPV	
Pneumococcal 13	
Pneumococcal 23	

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PATIENT INFORMATION

Name:_____ DOB:_____

SOCIAL HISTORY

Tobacco – Smoking

☐ Never ☐ Former ☐ Current ☐ Passive Smoke Exposure
☐ Cigarettes ☐ Pipe ☐ Cigar
Start Date: Quit Date: #Years: #Packs/day: _____

Tobacco – Smokeless

☐ Never ☐ Former ☐ Current
☐ Snuff ☐ Chew

E-Cigarettes

☐ Never ☐ Former ☐ Current
#Cartridges/day: Start Date:_____ Quit Date: _____

Alcohol

☐ Never ☐ Former
☐ Monthly or Less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
drinks per day typically when you are drinking: _____

Substance Abuse

☐ Never ☐ Former ☐ Current
Type:_____ How Often: _____

Sexually Active

☐ Never ☐ Not Currently ☐ Yes
☐ Male Partners ☐ Female Partners
Type of Birth Control / Protection: _____

Diet (check all that apply)

☐ Well Balanced ☐ Diabetic ☐ Excessive Fat/Calories ☐ Vegetarian
☐ Weight Loss Products ☐ Vitamin / Herbal Use ☐ Routine Mealtimes ☐ Caffeine
Other: _____

Exercise

days/week on average that you engage in moderate/strenuous activity (activity that causes light/heavy sweat): _____
minutes you exercise per day on average: _____

Safety

☐ CO detector in home ☐ Guns Unloaded/Locked ☐ Helmet use ☐ Seat Belt Use
☐ Smoke detector in home ☐ Sunscreen Use ☐ Water heater temp set ☐ Caffeine

With Whom Do You Live

☐ Alone ☐ Children ☐ Parent(s) ☐ Spouse/Partner
☐ Extended family ☐ Other

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Name:_____ DOB:_____
Last First MI mm/dd/yyyy

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes below, if known.

Relationship	Name	Status	No Known Problems	Alcohol abuse	Asthma	Blood clots	Breast cancer	Colon cancer	Prostate cancer	Other cancer(s)	Dementia	Diabetes	Heart disease	High blood pressure	High cholesterol	Kidney disease	Liver disease	Lung disease	Mental Illness	Ovarian Cancer	Stroke	Thyroid condition(s)	Other:_____	Other:_____	Other:_____
Mother		☐ Alive ☐ Deceased																							
Father		☐ Alive ☐ Deceased																							
Sister		☐ Alive ☐ Deceased																							
Brother		☐ Alive ☐ Deceased																							
Son		☐ Alive ☐ Deceased																							
Daughter		☐ Alive ☐ Deceased																							
Maternal Grandmother		☐ Alive ☐ Deceased																							
Maternal Grandfather		☐ Alive ☐ Deceased																							
Paternal Grandmother		☐ Alive ☐ Deceased																							
Paternal Grandfather		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							

Are you adopted?: ☐ Yes ☐ No

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Patient Label

Review of Systems
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Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS**:

General/ Constitution
- Activity Change
- Appetite Change
- Chills
- Diaphoresis (Sweating)
- Fatigue
- Fever
- Irritability
- Unexpected Weight Change

Ear, Nose & Throat
- Congestion
- Dental Problems
- Drooling
- Ear Discharge
- Ear Pain
- Facial Swelling
- Hearing Loss
- Mouth Sores
- Nosebleeds
- Postnasal Drip
- Rhinorrhea (Runny Nose)
- Sinus Pressure
- Sneezing
- Sore Throat
- Tinnitus (Ringing in the Ears)
- Trouble Swallowing
- Voice Change

Eyes
- Eye Discharge
- Eye Itching
- Eye Pain
- Eye Redness
- Photophobia (Sensitivity to Light)
- Visual Disturbance (Blurred Vision)

Respiratory
- Apnea
- Chest Tightness
- Choking
- Cough
- Shortness of Breath
- Stridor (Airway Obstruction)
- Wheezing

Cardiovascular
- Chest Pain
- Leg Swelling
- Palpitations (Irregular Heart Beat)

Gastrointestinal
- Abdominal Distention (Bloating)
- Abdominal Pain
- Anal Bleeding
- Blood in Stool
- Constipation
- Diarrhea
- Nausea
- Rectal Pain
- Vomiting

Endocrine
- Cold Intolerance
- Heat Intolerance
- Polydipsia (Abnormal Thirst)
- Polyphagia (Abnormal Hunger)
- Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- Arthralgias (Joint Pain)
- Back Pain
- Gait Problems
- Joint Swelling
- Myalgias (Muscle Pain)
- Neck Pain
- Neck Stiffness

Skin
- Color Change
- Pallor (Paleness)
- Rash
- Wounds

Allergy/Immunologic
- Environmental Allergies
- Food Allergies
- Immunocompromised

Neurologic
- Dizziness
- Facial Asymmetry
- Headache(s)
- Light Headedness
- Numbness
- Seizures
- Speech Difficulty
- Syncope (Loss of Consciousness)
- Tremors
- Weakness

Hematologic
- Adenopathy (Swollen Glands)
- Bruising Tendency
- Bleeding Tendency

Behavioral
- Agitation
- Behavioral Problems
- Confusion
- Decreased Concentration
- Dysphoric Mood (Mood Changes)
- Hallucinations
- Hyperactive
- Nervousness
- Anxiety
- Self Injury
- Sleep Disturbance
- Suicidal Thoughts

Any other symptoms: _____

Patient or Guardian Name (please print) | Patient or Guardian Signature | Date