H

Hopkins Family Med & Urgent Care, PLLC

MRN **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ☐ Male ☐ Female ☐ Other

Marital Status ☐Married ☐Single ☐Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other **Language** other than English

Race (Optional) ☐ Black – Non Hispanic ☐ American Indian/ Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White – Non Hispanic ☐ Other

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ⑨ Cell

Email Address **Employment Status** ☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employed ☐ Student FT ☐ Child ☐ Employed Part-Time ☐ Retired ☐ Student PT ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

Address **City** **State** **Zip Code** **Phone**

How did you hear about us? ☐ Employer ☐ Family Member ☐ Billboard ☐ Friend ☐ Health Fair ☐ Insurance Magazine Mail News ☐ Physician ☐ Radio ☐ Website ☐ Yellow Pages ☐ Other ☐ Television

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ⑨ Cell

Employer **Employment Status** ☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employed ☐ Student Full-Time ☐ Child ☐ Employed Part-Time ☐ Retired ☐ Student Part-Time ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ☐ Cell

Flip →

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4857 Manhattan Dr, Rockford, IL 61108 P: 815-708-0116 F: 815-708-0174

Allergies - Please list any allergies you have.

❑ **NO KNOWN DRUG ALLERGIES**

	Allergy	Reaction
1		
2		
3		
4		
5		
6		
7		

Medications - Please list any medications you are currently taking. PLEASE INCLUDE OVER THE COUNTER ITEMS

	Name	Dose	Frequency	Diagnosis
(Ex.)	(Lisinopril)	(10mg)	(Once a day)	(High Blood Pressure)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Please list any other **allergies AND reactions/ medications dose frequency and diagnosis use back of page if needed**

Past Medical History: Please check all that apply:

- ❑ Arthritis
- ❑ Blood transfusion (_____approx. yr(s).)
- ❑ Cancer
- ❑ Depression
- ❑ Anxiety
- ❑ Bipolar disorder
- ❑ Diabetes type 1 or 2
- ❑ Epilepsy/seizures
- ❑ Heart Failure
- ❑ Asthma
- ❑ COPD
- ❑ Heart surgery
- ❑ High blood pressure
- ❑ Psychiatric disease
- ❑ Stroke
- ❑ Thyroid
- ❑ **None**

Have you ever been hospitalized?when and why?

Have you had any serious injuries and/or broken bones?

Have you traveled outside of the US? When and where?

Other information on your Past Medical History:

Previous Surgeries: Please list past surgeries with approximate date:

Type	Date	Location/Facility

Comments/ Other surgeries Procedures below:

OB/GYN History:(Females)

Menstrual History:

- First day of last menstrual period _____
- Age at first menstrual period years _____
- Number of days from the start of one period to the start of the next _____days
- Number of days that you bleed _____days
- Describe the amount of menstrual flow → (circle one) light / moderate / heavy / clots
- Describe the amount of menstrual discomfort → (circle one) none / mild / moderate / severe
- Do you bleed in between your periods? → (circle one) Yes / No
- Do you bleed after intercourse? → (circle one) Yes / No
- If you stopped menstruating, at what age did you stop? _____years
- Have you had bleeding or spotting since your periods stopped? → Yes / No

Contraceptive and Sexual History:

- Present birth control method: _____
- Birth control methods used in the past: _____
- Have you ever been sexually active (had intercourse)? → Yes / No
- Have you had a new sexual partner in the past three months? → Yes / No
- How many sexual partners have you had in the past 3 months?
- Is/Are your partner(s) male, female, or both? Male / Female / Both
- Do you experience pain or discomfort with sexual intercourse? → Yes / No
- Would you like to discuss sexual activity or birth control today? → Yes / No

Gynecological History:

- Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil → Yes / No
- Last Pap Smear
- Last Mammogram
- Sexually transmitted diseases? Yes / No List: _____
- Fibroids Yes / No
- Endometriosis Yes / No
- Infertility Yes / No
- Urinary incontinence Yes / No

Obstetrical History: please record the number of:

- Pregnancies: _____
- Miscarriages: _____
- Vaginal Births: _____
- C-Sections: _____
- List any complications of pregnancies: _____

Social History: please circle Yes or No

- **Do you drink alcohol?**
  - ❑ Yes or No
  - ❑ If yes, how much/week? _____
- **Do you smoke?**
  - ❑ Yes or No
  - ❑ If yes, how many cigarettes/day? _____
- **Do you consume caffeine?**
  - ❑ Yes or No
  - ❑ If yes, how many cups/week? _____
- **Do you use recreational drugs?**
  - ❑ Yes or No
  - ❑ If yes, what type and frequency? _____
- **Are you on a special diet?**
  - ❑ Yes or No
  - ❑ If yes, please describe? _____

Family History:

Do you know of any blood relative who has or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑ Brain Tumor
- ❑ Cancer, Type:
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Headaches
- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ Migraine
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None
- ❑ Comments/other: _____

Immunization History:

Have you received the following **IMMUNIZATIONS**? If yes, indicate the approximate year it was last given:

- Pneumococcal (for pneumonia)
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Hepatitis A
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Hepatitis B
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Tetanus/Diphtheria within the last 10 years
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Influenza (flu)
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Measles
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Mumps
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Rubella
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____
- Polio
  - ❑ Yes ___ No ___ Unknown ___
  - ❑ Year _____

Review of Systems: Please check all that apply to you currently:

- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever/chills
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Painful chewing
- ❑ Ringing in ears
- ❑ Sinus infection
- ❑ Sores in mouth
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma
- ❑ Injury
- ❑ Pain
- ❑ Gastrointestinal
- ❑ Blood in stools
- ❑ Increasing constipation
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Persistent diarrhea
- ❑ Stomach or abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: vaginal discharge
- ❑ Kidney stones
- ❑ Male: prostate disease
- ❑ Male: testicle pain
- ❑ Painful or burning urination
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Urine retention/ incontinence
- ❑ Pain in chest
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heartbeat
- ❑ Back pain
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None Neurological
- ❑ Balance trouble
- ❑ Blackouts/loss of consciousness
- ❑ Difficulty speaking
- ❑ Difficulty walking
- ❑ Facial drooping
- ❑ Headaches
- ❑ Injury to the brain or spine
- ❑ Light-headed or dizziness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Migraines
- ❑ Mini stroke
- ❑ Neuropathy
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Stroke
- ❑ Tremors
- ❑ Weakness
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Asthma
- ❑ Blood in cough
- ❑ Cancer
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Color changes to skin
- ❑ Sleepwalking
- ❑ Nightmares
- ❑ Snoring/Episodes of not breathing? Yes or No
- ❑ Do you sleep well? Yes or No
- ❑ Do you feel rested when you wake? Yes or No
- ❑ Do you fall asleep during the day? Yes or No

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Preferred Pharmacy

Pharmacy Name:_____

Pharmacy Address:_____

City:_____ State:_____ Zip Code:_____

Pharmacy Phone:_____ Fax:_____