CLINICA MEDICA
SAN FELIPE

Patient Information

Patient's First Name:	MI:	Last Name:

Mailing Address:	Apt:	City:	State:	Zip Code:

Social Security:	Marital Status:	Birth Date: / /	Age:	Sex:

Guardian's Last Name (If patient is a minor):	Guardian's First Name:	Relationship to Patient:

Home Phone:	Cell Phone:	Email Address:

Preferred Method of Communication: Home Phone Cell Phone Email

May we leave a voice message at this phone number? Yes No

Please let us know if you would like to view your health information online via our Electronic Health Record System

Preferred Pharmacy:	Pharmacy Phone Number:

Employer:	Occupation:	Employer Phone Number:

In Case of Emergency

First Name of Contact:	Last Name of Contact:	Relationship to Patient:

Phone:

Additional Demographics

Race (check one)	Ethnicity (check one):
American Indian/Alaskan Native Black/African American Asian White Native Hawaiian/Pacific Islander Other:_________________	Hispanic or Latino Not Hispanic or Latino Unknown

Insurance

Primary Insurance:	Name of Primary Insured:

Insurance ID#:	Group #:	Effective Date:

ADULT HEALTH HISTORY

Patient Name: ____________________________________Age: ________Date of Birth: ______/____/______

Reason for today's visit:
Physical Exam Illness Medical Procedure Pregnancy Test Pap Smear Family Planning
Other: ____

Please list any **allergies** to food or medication: _________________________________

Please list all prescription & over-the-counter **medications**, vitamins, and herbals that you take:
1. ________________________ 2. ________________________ 3. ________________________
4. ________________________ 5. ________________________ 6. ________________________

Current Height :__________ Current Weight: __________ (Women) Are you pregnant? No Yes

Social History

Do you drink alcoholic beverages? No Yes: _________ drinks per day / week / month (circle)
Do you smoke tobacco? No Previously, but quit Socially Yes: _________ packer per day
Are you sexually active? No Yes
Have you been exposed to HIV (AIDS)? No Yes
Do you use recreational drugs? No Yes: ________________________
Marital Status: Single Married Separated Divorced Widowed

History of Past Illness (please check all that apply)

Epilepsy Stroke (s) Venereal Diseases (STD's)
Fainting Cancer Thyroid Disease
High Blood Pressure Rheumatic Fever Hepatitis
Chickenpox Heart Disease Any other serious disease (Please explain) :_______________
Diabetes Tuberculosis ____

Have you ever been Hospitalized? No Yes If yes, explain:_______________________________________
Have you had surgery? No Yes If yes, explain: _______________________________________
Have you had broken bones? No Yes If yes, explain: _______________________________________
Head injuries or concussions? No Yes If yes, explain: _______________________________________

Date of last Tetanus Shot:______________(Females) Last Pap Smear ______________Mammogram: ____________

Family History

Has anyone in your family ever had:

Cancer	No	Yes	If yes, who: __________________________
Diabetes	No	Yes	If yes, who: __________________________
Heart trouble/disease	No	Yes	If yes, who: __________________________
High blood pressure	No	Yes	If yes, who: __________________________
Suicidal attempts	No	Yes	If yes, who: __________________________

REVIEW OF SYSTEMS

Patient Name: ____ Date of Birth ______/______/______

General
- □ Fatigue
- □ Fever or chills
- □ Weakness
- □ Night sweats

Nose
- □ Stuffiness
- □ Discharge
- □ Itching
- □ Hay fever
- □ Nosebleeds

Neck
- □ Lumps
- □ Swollen glands
- □ Pain
- □ Stiffness

Throat
- □ Dental problems
- □ Gums
- □ Bleeding
- □ Dentures
- □ Sore tongue
- □ Dry mouth
- □ Sore throat
- □ Hoarseness
- □ Last dental exam: ___________
- □ Non-healing sores
- □ Thrush

Endocrine
- □ Unable to tolerate heat or cold
- □ Sweating
- □ Increased facial hair (females only)
- □ Unexpected weight gain or loss
- □ Frequent urination
- □ Thirst
- □ Change in appetite

Psychiatric
- □ Anxiety
- □ Stress
- □ Depression
- □ Suicidal or Homicidal thoughts
- □ Mood swings
- □ Memory loss

Lymph
- □ Swollen glands (armits or groin)

Hematologic
- □ Ease of bruising
- □ Ease of bleeding

Skin
- □ Rashes
- □ Lumps or Growths
- □ Sores
- □ Bleeding sites
- □ Itching
- □ Dryness
- □ Color changes
- □ Hair changes
- □ Nail changes

Ears
- □ Decreased hearing
- □ Ringing in ears
- □ Earache
- □ Drainage

Respiratory
- □ Cough (productive)
- □ Shortness of breath
- □ Wheezing
- □ Painful breathing

Cardiovascular
- □ Chest pain or discomfort
- □ Palpitations (heart racing)
- □ Shortness of breath with activity
- □ Fainting spells
- □ Swelling of legs
- □ Leg pain in calf/thigh
- □ Aching or Burning in legs
- □ High blood pressure

Neurologic
- □ Dizziness
- □ Fainting
- □ Seizures
- □ Repeated headaches
- □ Weakness
- □ Numbness
- □ Tingling
- □ Tremor
- □ Problems with memory or speech

Gastrointestinal
- □ Swallowing difficulties
- □ Heartburn
- □ Change in appetite
- □ Nausea / Vomiting
- □ Change in bowel habits
- □ Rectal bleeding
- □ Constipation
- □ Diarrhea
- □ Yellow eyes or skin

Eyes
- □ Glasses or contacts
- □ Pain
- □ Redness
- □ Blurry or double vision
- □ Last eye exam: _____________
- □ Cataracts
- □ Glaucoma

Musculoskeletal
- □ Muscle or joint pain
- □ Stiffness
- □ Limited motion of arms / legs
- □ Back pain
- □ Redness of joints
- □ Swelling of joints
- □ Trauma

Breasts (females)
- □ Lumps
- □ Swollen glands
- □ Discharge
- □ Breast-feeding

Genital

\- Males –
- □ Hernia
- □ Penile discharge
- □ Sores
- □ Masses or pain
- □ STD's
- □ Swelling in scrotum

\- Females -
- □ Vaginal discharge
- □ Itching or Rash
- □ STD's
- □ Irregular periods
- □ ≥ 3 yeast infections in 1 year

Urinary
- □ High urination frequency
- □ Burning or Pain during urination
- □ Blood in urine
- □ Incontinence

ACKNOWLEDGEMENT OF PATIENT PRIVACY

Notice to Patient:

Clinica Medica San Felipe is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). We may be required to share information with other medical providers for the benefit of your care. This is all within the regulations set by the Federal and State laws regarding PHI. Your information is only released with your written consent to do so and can be revoked at any time by you as provided by law. If you have any questions regarding this consent, please feel free to ask our staff members. We can provide you with a copy of our "Notice of Privacy Practices" at your request, which states how we may use and/or disclose your health information.

Please sign this form to acknowledge that you have had your questions regarding our privacy practices answered. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have had the opportunity to request a copy of this office's Notice of Privacy Practices.

______________________	X______________________	______________
Patient Name	Patient Signature	Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

REQUEST FOR MEDICAL SERVICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk to you about them. You may ask for a copy of this form for your records.

I may request information about the tests, treatments, and procedures to be provided including benefits, risks, possible side effects/complications and alternative choices. I understand that it is my duty as a patient to ask questions to my clinician about anything I do not understand.

I understand that it is my choice whether or not to accept services. I know that any time I may change my mind about receiving medical services.

I understand that if the tests for certain sexually transmitted infections are positive, reporting to a public health agency by this clinic is required by law.

I understand that if further diagnosis or treatment is needed for any medical concern, I will be given a referral. If a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told to get additional care in case of an emergency.

CONSENT FOR TREATMENT

I, the undersigned, hereby consent to the administration and performance of all diagnostic procedures and treatment which, in judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without consent of my attending physician, neither said physician nor Clinica Medica San Felipe shall be held liable for the consequences of such decision.

______________________	X______________________	______________
Patient Name	Patient Signature	Date