Family Care Clinic of Western Kansas, LLC

(Please Print)

Patient Information

Patient's last name:	Patient's first name:	Middle initial:	Today's Date:

Mailing address:	City:	State:	ZIP code:

Home phone no.: ( ) -	Cell phone no.: ( ) -	Work phone no.: ( ) -

Patient's date of birth: / /	Pt. age:	Patient's sex: M F	Patient's marital status: (Circle one) single engaged married divorced widowed

Social Security no.: - -	Employer's name:	Employer's address/Phone no.:

Employment status: (Circle one) student full time part time unemployed homemaker retired	Occupation:

Race: (Circle one) White Black Am. Indian Hispanic Asian Other Refused	Ethnicity: (circle one) Hispanic/Latino Not Hispanic/Latino

If patient is a minor:	Language Preference:(Circle one) English Spanish
Parent/Guardian name:	Relationship to patient:

In Case of Emergency

Name of emergency contact:	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -

Mailing address:	City:	State:	Zip code:

Insurance Information

Name of primary insurance:	Policy subscriber's name:	Social Security no.: - -	Date of birth: / /

Patient's relationship to subscriber: self spouse child other; please specify:_____

Name of secondary insurance: (if applicable)	Policy subscriber's name:	Social security no.: - -	Date of birth: / /

Patient's relationship to subscriber: self spouse child other; please specify:_____

Other Information

Pharmacy name:	Pharmacy address:	Pharmacy phone no.: ( ) -

How did you hear about this clinic, or who referred you here?

Responsible Party (Guarantor)

The guarantor is the person responsible for the patient's bill. **If the patient is responsible for his/her own bill, please skip to next section.** If the patient is a minor (under 18 yrs. old), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's last name:	Guarantor's first name:	Middle Initial:

Guarantor's mailing address, if different from patient:	City:	State:	ZIP code:

Guarantor's phone no.: ( ) -	Relationship to patient:	Guarantor's date of birth: / /	Guarantor's social security no.: - -

Family Care Clinic of Western Kansas, LLC

Patient Name:	**Today's Date: / /**

Medical Conditions:
Have you been diagnosed with any of the following conditions? (Check all that apply)

- ☐ High Blood Pressure
- ☐ Thyroid Condition
- ☐ Asthma
- ☐ Allergies
- ☐ HIV
- ☐ High Cholesterol
- ☐ Psychiatric Conditions
- ☐ Diabetes (type 1 or type 2?)
- ☐ Cancer (What type?_____)
- ☐ Heart Disease (What kind?_____)

Check the box and give the date if you have had any of the following:

	Date:		Date:
☐ Flu shot	_____	☐ Bone density test	_____
☐ Colonoscopy	_____	☐ Tetanus shot	_____
☐ Pneumonia shot	_____	☐ Last physical	_____
☐ Cholesterol	_____		

If you are a male:

Date:

☐ PSA _____

If you are a female:

Date:

Last Pap Smear: _____

Last Mammogram:_____

Number

☐ No. of pregnancies

☐ Number of children

Other Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree.

- ☐ Unexplained changes in weight
- ☐ Coughing
- ☐ Getting up at night to urinate frequently
- ☐ Excessive urination
- ☐ Loss of bladder control or leaking urine
- ☐ Mole that concern you
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Swelling or lumps in the breast
- ☐ Poor memory or memory loss
- ☐ Depression
- ☐ Intolerance of cold
- ☐ Chest pain
- ☐ Blood in stool or dark black stool
- ☐ recent joint or muscle pain
- ☐ Passing out or loss of consciousness
- ☐ Excessive thirst
- ☐ Intolerance of heat

Social History

Tobacco: (Circle one) non-smoker former smoker smoker			(Circle one) cigarettes cigars pipe smokeless
Years of tobacco use:	Packs/cans per day:	Desire to quit?(Circle one) Yes No	
Alcohol:(circle one) None Beer Wine Other:_____			Weekly amount:
Have you ever used illicit drugs? (Circle one) Yes No			
Do you exercise regularly? Yes No	What type of exercise?		

List any surgeries you have had and the dates (Need more room? Use the back of this page)

Date:	Surgery:	Date:	Surgery:

Patient Name:	**Today's Date: / /**

List all medications that you take including prescribed drugs, inhalers, over-the-counter medications, herbal medications, etc.

Name of drug:	Strength:	Frequency taken:

List any allergies to medications (Need more room? Use the back of this page)

Name of drug:	Reaction you had:

Family Health History

(Please check all that apply.)	Coronary heart disease	Heart Attack	Stroke/CVA	High Blood Pressure	High Cholesterol	Diabetes - Type 1 or 2?	Thyroid Disease	Alcoholism	Depression	Breast Cancer	Colorectal Cancer	Other Cancer (Please specify)	Other: (please specify)		Living?	Deceased? What age?
Father																
Mother																
Brother(s)																
Sister(s)																
Maternal Grandmother																
Maternal Grandfather																
Paternal Grandmother																
Paternal Grandfather																
Maternal Aunts or Uncles																
Paternal Aunts or Uncles																

Any other pertinent information you would like tohave contained in your chart? _____

_____

_____

Do you have an Advanced Directive, Living Will, or Durable Power of Attorney for Health Care Decisions?
(circle one) Yes No (If yes, please provide the front office with it so a copy may be placed in your chart.)