FAMILY HEALTH CARE
MEDICAL GROUP OF MODESTO

HEALTH HISTORY Date of Birth_____

Patient_____Age_____ Sex_____ Birthplace_____

Family Structure: Head of household_____ Date of birth_____

Spouse_____ Date of birth_____

Children_____ Sex _____ Date of birth_____

_____Sex _____ Date of birth_____

_____Sex _____ Date of birth_____

_____Sex _____ Date of birth_____

MAJOR HEALTH PROBLEMS OR ILLNESSES (in order of importance or concern to you)**:**

1._____ 2._____

3._____ 4.._____

OPERATIONS:

1._____ 2._____

3._____ 4._____

HOSPITALIZATIONS OTHER THAN OPERATIONS (year, reason and doctor)**:**

1._____ 2._____

3.._____ 4._____

MEDICATIONS CURRENTLY BEING TAKEN:

1._____ 2._____

3.._____ 4._____

ALLERGIES:_____

Date of last TB skin test_____Last tetanus shot_____
Do you smoke?_____ Drink alcohol?_____ Do you consider it a problem?_____
Do you consider your weight a problem?_____ What is your "ideal" weight?_____

FOR WOMEN ONLY: How many pregnancies?_____ Miscarriages_____ Therapeutic abortions_____
Living children_____ Last menstrual period began on _____
First period at what age?_____ Last pap smear done_____ Normal?_____
Are you presently using birth control?_____ What method?_____
Last mammogram done ? _____ Normal ? _____
FOR CHILDREN: Birth weight_____ Length_____ Full term pregnancy?_____
Problems during pregnancy?_____ During delivery or just after?_____

IMMUNIZATIONS AND DATES (we can photocopy your record book if you have it with you)**:**

NEW PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) MARITAL STATUS	DOB AGE SS#		DL#
STREET ADDRESS	CITY & STATE ZIP		HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION HOW LONG EMPLOYED?		BUS. PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY & STATE		ZIP
NAME & ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU	RELATIONSHIP		PHONE NO.
SPOUSE'S NAME	DATE OF BIRTH		SOCIAL SECURITY #
SPOUSE'S EMPLOYER	OCCUPATION HOW LONG EMPLOYED?		BUS. PHONE NO.
EMPLOYER'S ADDRESS	CITY & STATE		ZIP
SPOUSE'S STREET ADDRESS (IF DIFFERENT FROM PATIENT)	CITY & STATE ZIP		HOME PHONE NO.

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME DOB:	STREET ADRESS, CITY, STATE & ZIP CODE		HOME PHONE NO.
MOTHER'S EMPLOYER	OCCUPATION HOW LONG EMPLOYED?		BUS. PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP
FATHER'S NAME DOB:	STREET ADDRESS,CITY, STATE & ZIP CODE		HOME PHONE NO.
FATHER'S EMPLOYER	OCCUPATION HOW LONG EMPLOYED?		BUS. PHONE NO.
EMPLOYER'S ADDRESS	CITY AND STATE		ZIP

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE DOB:	STREET ADDRESS, CITY, STATE & ZIP CODE		HOME PHONE NO.
INSURANCE COMPANY SUBSCRIBER	POLICY #/GROUP #/COVERAGE CODE		FAMILY COVERAGE?
OTHER INSURANCE INFORMATION			FAMILY COVERAGE?

I AUTHORIZE FAMILY HEALTH CARE MEDICAL GROUP (FHCMG) TO PROVIDE ANY MEDICAL TREATMENT DEEMED NECESSARY BY THE ATTENDING PHYSICIAN. I ALSO AUTHORIZE FHCMG TO RELEASE INFORMATION REGARDING MY TREATMENT OR EXAM TO INSURANCE COMPANIES OR ITS REPRESENTATIVES. I AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO FHCMG IN THE AMOUNT DUE FOR MY CHARGES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE , WITHIN 30 DAYS, FOR ANY DEDUCTIBLES, NONCOVERED SERVICES, OR PATIENT LIABILITIES AS INDICATED BY MY INSURANCE COMPANY.

_____ DATE:_____

Signature of Patient or Legal Guardian/Parent if Minor

REFERRED BY_____

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