

**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 ADDRESS, 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.

Signature of Patient or Legal Guardian/Parent if Minor _____ DATE: _____

REFERRED BY _____