DESERT EDGE MEDICAL

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PATIENT INFORMATION

Patient Name: _____ ***Sex:*** ☐*Male* ☐*Female* ☐ *Other*

Address: _____ ***Date of Birth:*** ____/____/____

City: _____ ***State:*** _____ ***Zip Code:*** _____

Is Mailing Address Same as above? ☐ *Yes* ☐ *No* ***If no, mailing address:*** _____

State _____ ***Zip Code:*** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Preferred Communication: ☐ Home ☐ Cell **Required Social Sec #:** _____

Why are you visiting the doctor today? _____

_____

Referring and/or Primary Care Physician: _____

1. **RACE(Please check one)**
   - ☐ American Indian/Alaska Native
   - ☐ Asian
   - ☐ Black/African American
   - ☐ More than one race
   - ☐ Native Hawaiian
   - ☐ Pacific Islander
   - ☐ White/Caucasian
   - ☐ Decline

2. **ETHNICITY(Please check one)**
   - ☐ Hispanic/Latino
   - ☐ Non-Hispanic/Latino
   - ☐ Decline

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION*Complete if insurance is under ***SPOUSE***, ***PARENT*** OR ***DIFFERENT NAME***

Name: _____ Relationship to Patient: _____

Mailing Address: _____

Primary Phone: _____ Date of Birth: ____/____/____ Social Sec #: _____

OFFICE USE ONLY: Scanned____ Entered____

HIPAA/RELEASE OF INFORMATION

Under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are not allowed to give this information to anyone without the patient's expressed written consent. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

1. Should you ever need a copy of any and/or all of you medical records please print below **authorizing** Desert Edge Medical to release your medical information to YOU.

_____ Date of Birth: _____
(Print Patient Name)

2. If you wish to have any and/or all of your medical records released to someone other than yourself (e.g., family member, another physician, attorney) please indicate their name and relationship to you below.

I ***authorize*** Desert Edge Medical to ***release*** my medical and/or financial information (as indicated below) to the following individuals:

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

3. _____ Relationship to Patient: _____

4. _____ Relationship to Patient: _____

By **signing** below, I agree the information above is correct.

_____ _____
Signature of patient or patient's representative Date

_____
Printed name of patient or patient's representative

ALLERGIES

Have you had an allergic reaction to any of the following?

☐Adhesive Tape ☐Anesthesia ☐Aspirin ☐Latex ☐Iodine/Shellfish/Contrast Dye ☐Codeine ☐Morphine

☐Penicillin ☐Sulfa Drugs ☐Other:_____ ☐**No Known Drug Allergies**

FAMILY HISTORY

Is there a history of any of the following in your **immediate family**? ☐**N/A**

M – Mother **F** – Father **S** – Sister **B** – Brother ☐**Adopted, family history unknown**

	M	F	S	B		M	F	S	B		M	F	S	B
Anesthesia Problems					Headache/Migraine					Osteoporosis				
Arthritis					Cardiovascular Problems					Seizures				
Bleeding Disorders					Hypertension					Stroke (CVA)				
Cancer (Type):					Kidney Disease					Substance Abuse				
Chronic Pain					Liver Disease					Other:				
Diabetes: Type 1 or 2 Circle one					Mental Illness					Other:				

Please circle the appropriate answer

Mother: Living Deceased **Father:** Living Deceased **Sister/Brother:** Living Deceased **(circle one)**

Sister/Brother: Living Deceased **Sister/Brother:** Living Deceased **Sister/Brother:** Living Deceased

SOCIAL HISTORY

Occupation:

☐ Full-Time: _____
☐ Part-Time: _____
☐ Retired
☐ Disabled
☐ Unemployment
☐ Student

Marital Status:

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Domestic Partner
☐ Separated

Do you?

SMOKE: ☐Yes ☐No ☐Former
How many years?_____
How many packs per day?_____
CHEW: ☐Yes ☐No ☐Former
How many years?_____
ALCOHOL: ☐Never ☐Weekly ☐Seldom

Have you ever abused alcohol? ☐Yes ☐ No

Have you ever used any illicit substances? ☐Yes ☐ No Type:_____

Have you ever been addicted to or misused prescription drugs? ☐Yes ☐ No Type:_____

MEDICAL HISTORY: Do you have a history of any of the following?

☐Seasonal Allergies ☐Anemia ☐Anxiety ☐Arthritis ☐Asthma ☐COPD ☐Chest Pain

☐Cancer, Type:_____ ☐Congestive Heart Failure ☐Coronary Artery Disease ☐Depression

☐Diabetes: (Type 1) (Type 2) ☐Fibromyalgia ☐Heart Disease ☐Hypertension ☐Hyper/Hypo-thyroidism
Last A1C:_____

☐Headaches:(Migraine) (Cluster) (Tension) ☐Hepatitis ☐HIV or AIDS ☐Kidney Failure
Circle One:

☐Infection Problems:_____ ☐Liver Disease ☐Neuropathy ☐Osteoporosis

☐Shortness of breath ☐**NONE of the problems Listed** ☐Other:_____

OTHER PROVIDERS

Please list Specialists and any other providers you may also be seeing or have seen in the past ☐ **N/A**

Provider Name	Specialty

SURGICAL HISTORY

Please list all previous surgeries ☐ **N/A**

Type of Surgery	Right or Left	Year/Date	Doctor and/or Location

CURRENT MEDICATIONS

Please list all prescriptions, OTC, herbal, and/or vitamin (nutritional) supplements you are currently taking. ☐ **N/A**

PREFERRED PHARMACY:_____

Name of Medication	Dosage (mg, mcg, mL)	Frequency

Signature of patient or legal representative: _____ Date: _____

If signed by legal representative, relationship to patient: _____ Signature of witness (Office): _____

REVIEW OF SYMPTOMS

GENERAL
- ☐ Change in Appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

SKIN
- ☐ Dry skin
- ☐ Excessive sweating
- ☐ Hives
- ☐ Jaundice
- ☐ Loss of hairs
- ☐ Mole changes
- ☐ Rash
- ☐ Ulcers
- ☐ Warts

HEAD
- ☐ Head Injury

EYES
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Changes in vision
- ☐ Color blindness
- ☐ Double vision
- ☐ Dry Eyes
- ☐ Eye itching
- ☐ Eye pain
- ☐ Glasses or contacts
- ☐ Glaucoma
- ☐ Night blindness

EARS
- ☐ Deafness
- ☐ Dizziness
- ☐ Hearing loss
- ☐ Tinnitus
- ☐ Hearing aids

NOSE & SINUSES
- ☐ Facial Pressure
- ☐ Loss of smell
- ☐ Nasal Congestion
- ☐ Nasal Irritation
- ☐ Nose Bleeds
- ☐ Postnasal drip
- ☐ Sinus Headache
- ☐ Sinus pain
- ☐ Sinus problem

MOUTH & THROAT
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Metallic Taste
- ☐ Wears Dentures

NECK
- ☐ Enlarged Thyroid
- ☐ Neck Mass
- ☐ Neck Pain
- ☐ Stiffness
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chest Pain
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Snoring
- ☐ Tuberculosis
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Edema
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Murmur
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallstones
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Indigestion
- ☐ Nausea

GENITOURINARY
- ☐ Incontinence
- ☐ Frequency
- ☐ Kidney Stones
- ☐ Nocturia
- ☐ Urgency

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Back Pain
- ☐ Gout
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Stiffness

HEMATOLOGIC
- ☐ Anemia
- ☐ Easy Bruising

NEUROLOGIC
- ☐ Abnormal Gait
- ☐ Clumsiness
- ☐ Disorientation
- ☐ Dizziness
- ☐ Headache:
  - ☐ Migraine
  - ☐ Sinus
  - ☐ Tension
- ☐ Involuntary Movements
- ☐ Memory Loss
- ☐ Numbness
- ☐ Seizure
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Binging
- ☐ Depression
- ☐ Insomnia
- ☐ Irritability
- ☐ Purging

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Excessive Hunger
- ☐ Foot Ulcers
- ☐ Heat Intolerance
- ☐ Unusual Hair Loss

☐ **N/A**

REVIEW OF PREVENTATIVE SERVICES:

PLEASE check each one that has been completed and **ENTER DATE (MO/YR) when last done)

VACCINATIONS & IMMUNIZATIONS:

Flu Shot

☐ Yes: _____ ☐ No

COVID-19 Vaccine

☐ Yes: _____ ☐ No

Pneumonia shot

☐ Yes: _____ ☐ No

Tetanus Shot

☐ Yes: _____ ☐ No

Zoster-Shingles

☐ Yes: _____ ☐ No

SCREENINGS:

Bone Density Scan

☐ Yes: _____ ☐ No

Colonoscopy

☐ Yes: _____ ☐ No

AAA Screening (*Abdominal Aortic Aneurysm*)

☐ Yes: _____ ☐ No

Eye Exam

☐ Yes: _____ ☐ No

DIABETIC REVIEW:

Retinal Eye Exam:

☐ Yes: _____ ☐ No

Diabetic Foot Exam:

☐ Yes: _____ ☐ No

Urinalysis – Creatinine/Albumin:

☐ Yes: _____ ☐ No

Hemoglobin A1C:

☐ Yes: _____ ☐ No

WOMEN ONLY:

Mammogram

☐ Yes: _____ ☐ No

Pap smear

☐ Yes: _____ ☐ No

MEN ONLY:

Prostate-specific antigen (PSA – Blood Test)

☐ Yes: _____ ☐ No