PLEASE PRINT

Date:_____/_____/_____ Home Phone: (_____)_____-_____

PATIENT INFORMATION

Name:_____Social Security:_____

Address: _____Cell Phone: (_____)_____-_____

City:_____ State:_____Zip Code:_____

Sex: M [ ] F [ ] Age:_____ Birth Date: _____/_____/_____ Race: _____

Ethnicity:_____ Preferred Language:_____ Blind: [ ] Deaf: [ ]

☐ Married ☐ Widowed ☐ Single ☐ Divorced

☐ Minor ☐ Separated ☐ Partnered for years

Patient Employer/School: _____ Occupation:_____

Employer/School Phone: (_____)_____-_____ E-mail: _____

Whom may we thank for referring you?:_____

Emergency Contact:_____Phone:(_____)_____-_____

PRIMARY INSURANCE

Person Responsible for Account:_____Relation to Patient:_____

Birth Date:_____/_____/_____ Social Security #:_____

Address:_____Phone: (_____)_____-_____

Person Responsible Employed by:_____ Occupation:_____

Business Address:_____Business Phone: (_____)_____-_____

Insurance Company:_____Phone: (_____)_____-_____

Member ID:_____Group:_____Subscriber:_____

Names of other dependents covered under this plan:_____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? Yes [ ] No [ ]

Person Responsible for Account:_____Relation to Patient:_____

Birth Date:_____/_____/_____Social Security #:_____

Address:_____Phone: (_____)_____-_____

Person Responsible Employed by:_____ Occupation:_____

Insurance Company:_____Phone: (_____)_____-_____

Member ID:_____Group:_____Subscriber:_____

Names of other dependents covered under this plan:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr._____. All insurance benefits, if any, otherwise will be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Confidential Health History

Patient Name:_____Today's Date:_____/_____/_____

Age:_____Birth Date:_____/_____/_____Date of last physical:_____/_____/_____

What is your reason for this visit:_____

SYMPTOMS

Check conditions you currently have or have had in the past year

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

ENT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Doubled vision
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes
- ☐ Vision - halos

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Men Only

- ☐ Breast lump
- ☐ Erectile dysfunction
- ☐ Lump in testes
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

Women only

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Menstrual pain
- ☐ Hot flashes
- ☐ Nipples discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last period:

_____/_____/_____

Date of last pap smear:

_____/_____/_____

Date of last mammogram

_____/_____/_____

Are you pregnant? Y N

Number of children:

CONDITIONS

Check the conditions you currently have or have had in the past year

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chick pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric Care
- ☐ Rheumatic
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Medications: list medications you are currently taking:

_____ _____ _____

_____ _____ _____

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? [ ] Yes [ ] No

If yes, please give approximate dates:_____

Pregnancies

Year of Birth	Sex	Complications if any

Health Habits

Check which you use and how often

- [ ] Caffeine _____
- [ ] Tobacco _____
- [ ] Street Drugs_____
- [ ] Other _____

Serious Illnesses/Injuries

Serious Illnesses/Injuries	Date	Outcome

Occupational

Check if your work exposes you to:

- [ ] Stress
- [ ] Hazardous Substances
- [ ] Heavy Lifting
- [ ] Other:_____

Occupation_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

Forte Family Practice Health Questionnaire-9 (PHQ-9)

Today's Date:_____/_____/_____

Patient Name:_____Date of Birth:_____/_____/_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answer:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or or hurting yourself in some way	0	1	2	3
For Office Coding: _____+_____+_____+_____ = Total Score: _____				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

The Alcohol Use Disorders Identification Test
(AUDIT)

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Please read the following questions and record your answer.

1. How often do you have a drink containing alcohol?
   (0) Never [skip to ?s 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 0
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a results of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Total Score: