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DATE:______________________________

PATIENT DEMOGRAPHICS

NAME:____
FIRST MIDDLE LAST

☐ MALE ☐ FEMALE

DATE OF BIRTH:______________________ SOCIAL SECURITY #:_______ - _______ - ___________

STREET ADDRESS:____

CITY:______________________________ STATE:___________________________ ZIP CODE:______________________

PRIMARY PHONE:____

SECONDARY PHONE:____

E-MAIL ADDRESS:____

PRIMARY INSURANCE:

____

SUBSCRIBER ID:____________________________

GROUP ID: ________________

SECONDARY INSURANCE (IF APPLICABLE):

____

SUBSCRIBER ID:____________________________

GROUP ID: ________________

NEXT OF KIN (FOR EMERGENCY):____

RELATION:__________________________ PHONE:__________________________________

LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

1. ______________________________________ 2. ______________________________________

3. ______________________________________ 4. ______________________________________

LIST ANY PHYSICIANS AND/OR PRACTITIONERS YOU CURRENTLY SEE

NAME: ______________________________________ SPECIALTY: ______________________________

NAME: ______________________________________ SPECIALTY: ______________________________

NAME: ____________________ SPECIALTY: ____________________

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

	NAME	STRENGTH	DIRECTION	PRESCRIBED BY
1.				
2.				
3.				
4.				
5.				
6.				

LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

5. ____________________ 6. ____________________

RECORD THE LAST YEAR YOU HAD THE FOLLOWING. IF YOU DO NOT KNOW, LEAVE BLANK

COVID19 VACCINE YEAR:	BONE DENSITY SCAN YEAR:	COLONOSCOPY YEAR:
COVID19 BOOSTER (1) YEAR:	MAMMOGRAM YEAR:	PROSTATE EXAM YEAR:
COVID19 BOOSTER (2) YEAR:	ECHOCARDIOGRAM YEAR:	RECTAL EXAM YEAR:
PNEUMONIA VACCINE YEAR:	PAP SMEAR YEAR:	PELVIC EXAM YEAR:
SHINGLES VACCINE YEAR:	GLUCOSE READING YEAR:	HEARING EXAM YEAR:
HEPATITIS B SHOT YEAR:	HEMOCCULT TEST YEAR:	GLAUCOMA/EYE EXAM YEAR:
FLU VACCINE YEAR:	PSA TEST YEAR:	NUTRITIONAL THERAPY YEAR:
TETANUS DIPHTHERIA YEAR:	LIPID PANEL YEAR:	SMOKING CESSATION YEAR:
ABDOMINAL AORTIC ANEURYSM SCREENING YEAR:		
DIABETES SELF-MANAGEMENT TRAINING YEAR:		

LIST ANY PAST SURGERIES OR HOSPITALIZATIONS

1. ____________________ YEAR: ______ 2. ____________________ YEAR: ______

3. ____________________ YEAR: ______ 4. ____________________ YEAR: ______

5. ____________________ YEAR: ______ 6. ____________________ YEAR: ______

LIST ANY CHILDHOOD ILLNESSES

1. ______________________________ 2. ______________________________

LIST HEALTH PROBLEMS AND CAUSES OF DEATH, IF APPLICABLE

			AGE	MEDICAL PROBLEMS
FATHER	LIVING _____	DECEASED _____	_____	__________
MOTHER	LIVING _____	DECEASED _____	_____	__________
BROTHER(S)	LIVING _____	DECEASED _____	_____	__________
SISTER(S)	LIVING _____	DECEASED _____	_____	__________

SOCIAL HISTORY

LIST EVERYONE IN YOUR HOUSEHOLD (INCLUDING PETS):			
1.		5.	
2.		6.	
3.		7.	
4.		8.	

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER:__________

OCCUPATION:__________ HOW LONG AT CURRENT EMPLOYER?:__________

EDUCATION: ☐ HIGH SCHOOL ☐ COLLEGE ☐ SOME COLLEGE ☐ TRADE SCHOOL ☐ OTHER:__________

DIET: ☐ BALANCED ☐ VEGETARIAN ☐ DIABETIC ☐ LOW SALT ☐ LOW FAT ☐ LOW CARB ☐ OTHER:__________

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? ☐ YES ☐ NO IF YES, HOW MUCH?__________

PLEASE INDICATE IF YOU DO OR DO NOT NEED HELP PERFORMING THESE ROUTINE TASKS

DO YOU FIND IT DIFFICULT TO FOLLOW A CONVERSATION IN A CROWDED ROOM?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL THAT PEOPLE ARE MUMBLING OR NOT SPEAKING CLEARLY?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU EXPERIENCE DIFFICULTY FOLLOWING DIALOGUE IN A THEATER?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FIND YOURSELF ASKING PEOPLE TO SPEAK UP OR REPEAT THEMSELVES?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FIND MEN'S VOICES EASIER TO UNDERSTAND THAN WOMEN'S?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU EXPERIENCE DIFFICULTY UNDERSTANDING SOFT/WHISPERED SPEECH?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL HANDICAPPED BY A HEARING PROBLEM?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU EXPERIENCE RINGING/NOISES IN YOUR EARS?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU HEAR BETTER WITH ONE EAR THAN THE OTHER?	☐ YES ☐ NO ☐ SOMETIMES
HAVE ANY OF YOUR RELATIVES (BY BIRTH) HAD HEARING LOSS?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU HAVE DIFFICULTY UNDERSTANDING SPEECH ON THE TELEPHONE?	☐ YES ☐ NO ☐ SOMETIMES
DOES A HEARING PROBLEM CAUSE YOU TO FEEL EMBARASSED MEETING PEOPLE?	☐ YES ☐ NO ☐ SOMETIMES

DO YOU FIND IT DIFFICULT TO UNDERSTAND A SPEAKER AT A PUBLIC MEETING/EVENT?	☐ YES ☐ NO ☐ SOMETIMES
DOES A HEARING PROBLEM CAUSE YOU TO VISIT FRIENDS/FAMILY LESS OFTEN THAN YOU WOULD LIKE?	☐ YES ☐ NO ☐ SOMETIMES
HAVE YOU HAD ANY SIGNIFICANT NOISE EXPOSURE DURING WORK, RECREATION, OR MILITARY SERVICE?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL LITTLE INTEREST/PLEASURE IN DOING THINGS?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL DOWN, DEPRESSED OR HOPELESS?	☐ YES ☐ NO ☐ SOMETIMES
ARE YOU AFRAID OF FALLING?	☐ YES ☐ NO ☐ SOMETIMES
HAVE YOU FALLEN IN THE PAST YEAR?	☐ YES ☐ NO ☐ SOMETIMES

FEEDING YOURSELF	☐ YES ☐ NO IF YES, WHO HELPS?________________________
GETTING FROM BED TO CHAIR	☐ YES ☐ NO IF YES, WHO HELPS?________________________
GETTING TO THE TOILET	☐ YES ☐ NO IF YES, WHO HELPS?________________________
GETTING DRESSED	☐ YES ☐ NO IF YES, WHO HELPS?________________________
BATHING OR SHOWERING	☐ YES ☐ NO IF YES, WHO HELPS?________________________
USING THE TELEPHONE	☐ YES ☐ NO IF YES, WHO HELPS?________________________
TAKING YOUR MEDICINES	☐ YES ☐ NO IF YES, WHO HELPS?________________________
PREPARING MEALS	☐ YES ☐ NO IF YES, WHO HELPS?________________________
SHOPPING FOR GROCERIES	☐ YES ☐ NO IF YES, WHO HELPS?________________________
DRIVING	☐ YES ☐ NO IF YES, WHO HELPS?________________________
CLIMBING A FLIGHT OF STAIRS	☐ YES ☐ NO IF YES, WHO HELPS?________________________
MANAGING MONEY (TRACKING EXPENSES/PAYING BILLS)	☐ YES ☐ NO IF YES, WHO HELPS?________________________
WALKING ACROSS THE ROOM (WITH A CANE/WALKER)	☐ YES ☐ NO IF YES, WHO HELPS?________________________
MODERATELY STRENUOUS HOUSEWORK (LAUNDRY)	☐ YES ☐ NO IF YES, WHO HELPS?________________________
SHOPPING FOR PERSONAL ITEMS (TOILETRIES/MEDICINES)	☐ YES ☐ NO IF YES, WHO HELPS?________________________

HAVE YOU EVER SMOKED OR CHEWED TOBACCO? ☐ YES ☐ NO IF YES, HOW MUCH?________________________

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH?________________________

ARE OTHERS CONCERNED ABOUT YOUR DRINKING? ☐ YES ☐ NO

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ☐ YES ☐ NO

______________________________________   ____/____/____

AUTHORIZED SIGNATURE   DATE