SILVER PINE MEDICAL GROUP

PATIENT INFORMATION

Date: _____

Please Print

Last	First	MI	Birth date	☐ M ☐ F Sex	/ / Social Security Number

Address	City	State	Zip

Contact Numbers

Home Phone _____
Work Phone _____
Cell Phone _____

Primary Language

☐ English ☐ Italian ☐ Polish
☐ Spanish ☐ Arabic ☐ German
☐ French ☐ Hindi ☐ Other
☐ Greek ☐ Japanese

Marital Status

☐ Single ☐ Widowed
☐ Married ☐ Separated
☐ Divorced

Race

☐ Caucasian ☐ African American
☐ Asian ☐ More than one race
☐ Native Hawaiian ☐ Other Pacific Islander
☐ Native American / Alaska Native ☐ Unreported/ Refused

Ethnicity

☐ German ☐ Russian ☐ Native American
☐ Italian ☐ Serbian ☐ Spanish
☐ Greek ☐ Polish ☐ Portuguese
☐ Albanian ☐ English ☐ Other/Unreported

Employer _____ Occupation _____

Email Address _____

INSURANCE HOLDER

☐ Check here if you, the patient, are the responsible party

Last	First	MI	Birth date	☐ M ☐ F Sex	/ / Social Security Number

Address	City	State	Zip

RESPONSIBLE PARTY

Last	First	MI	Birth date	☐ M ☐ F Sex	/ / Social Security Number

Address	City	State	Zip

EMERGENCY CONTACT (Please Print)

Name _____ Phone # _____ Relationship _____

REFERRED BY

☐ Family or Friend ☐ Internet ☐ Other (please specify)
☐ Beaumont Hospitals ☐ Urgent Care _____
☐ Advertisement (please specify) ☐ Other Physician (please specify)
_____ _____

PATIENT HISTORY

15 Years and Older

MEDICAL HISTORY

- ☐ Hypertension (high blood pressure)
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Diabetes
- ☐ Heart / Palpitations / Heart Attack
- ☐ Cancer : _____
- ☐ Lung / Asthma
- ☐ Thyroid Problem
- ☐ Joint Pain
- ☐ Eye / Vision
- ☐ Depression / Anxiety
- ☐ Stomach
- ☐ Headache / Seizures
- ☐ Back Pain
- ☐ Kidney / Urine
- ☐ Insomnia (difficulty sleeping)
- ☐ Other: _____

HOSPITAL ADMISSIONS / OPERATIONS

Year	Illness or Operations

ALLERGIES

_____
_____
_____
_____

MEDICATIONS

_____
_____
_____
_____

IMMUNIZATIONS

(Please write approximate date)

Meningitis:_____Tetanus:_____ Pneumonia: _____ Influenza: _____ Gardasil:_____

FAMILY HISTORY

Please list any family history of medical issues

Mother: _____ Living: Y N

Father: _____ Living: Y N

Sisters: # ____ _____ Living: Y N

Brothers: # ____ _____ Living: Y N

SOCIAL HISTORY

Do you wear seat belts? Y N

Do you exercise? Y N

Do you chew or smoke tobacco? Y N

IF YES:

How long have you used tobacco? _____

How much do you use daily? _____

IF NO:

Have you in your past? Y N

If you quit, how long ago? _____

Do you consume alcohol? Y N

How much per day _____ week _____ month _____

Are you sexually active? Y N

Men ☐ Women ☐ Both ☐

Are you happy with your life? Y N

Are you exposed to hazardous materials at work? Y N

What type of work do you currently do? _____

Do you travel out of the country? Y N

Are you a student? If yes, (circle one) FT or PT Y N

WOMEN

Age you started your period? _____

Number of pregnancies? _____

Number of live births? _____

Start of last menstrual period? _____

Do you have sexual concerns? Y N

Do you use condoms? Y N

Do you use birth control? Y N

MEN

Do you have sexual concerns? _____

Do you use condoms? _____