

Hope Medical Clinic Adult Patient Profile

Patient First Name <small>Print</small>		M.I.	Last Name		Date of Birth <small>MM/DD/YYYY</small>	Today's Date <small>MM/DD/YYYY</small>			
Address <small>Number Street</small>				<small>Lot/Apt</small>	<small>City</small>	<small>State</small>	<small>Zip</small>		
Home Phone <small>Area Code</small>		Cell Phone <small>Area Code</small>		Work Phone <small>Area Code</small>		SSN/Visa/Green Card (circle type); if none, year arrived in USA			
<input type="checkbox"/> male	Ethnicity (mark 1)	<input type="checkbox"/> Am Indian/Alaska Native	<input type="checkbox"/> Black/African	<input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> Unknown			
<input type="checkbox"/> female		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Other		<input type="checkbox"/> White non-Hispanic			
Primary Language Spoken:			Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed						
Emergency Contact Person <small>Name</small>			Relationship to Patient		Contact's Phone <small>Area Code Number Ext</small>				
RELIGION/CHURCH:									
Do you have Medicaid, Medicare, WHP, or other health coverage? <input type="checkbox"/> no <input type="checkbox"/> yes		Have you applied for any of these? <input type="checkbox"/> no <input type="checkbox"/> yes		Are you a veteran? <input type="checkbox"/> no <input type="checkbox"/> yes		Have you received healthcare elsewhere in the last two years? <input type="checkbox"/> no <input type="checkbox"/> yes			
CURRENT MEDICATIONS: List all medications you are (or believe you should be) currently taking:									
ALLERGIES: <input type="checkbox"/> Check here if you know of no drug allergies, or list below medications and substances you are allergic to or have a bad reaction to:									
Medication/substance name		Describe Reaction		Medication/substance name		Describe Reaction			
TETANUS: Date of last tetanus shot: _____									
SURGERIES AND HOSPITALIZATIONS: List the approximate date and reason for each surgery or hospitalization									
Date					Date				
HEALTH HABITS									
Do you or have you ever smoked or chewed tobacco? <input type="checkbox"/> no <input type="checkbox"/> yes		How many cigarettes a day?		At what age did you start?		When did you quit?		Would you like to quit? <input type="checkbox"/> no <input type="checkbox"/> yes	
Do you use alcohol? <input type="checkbox"/> no <input type="checkbox"/> yes		What kind?				How often? Per day/week		Would you like to quit? <input type="checkbox"/> no <input type="checkbox"/> yes	
Do you use recreational drugs? <input type="checkbox"/> no <input type="checkbox"/> yes		What kind?				How often? Per day/week		Would you like to quit? <input type="checkbox"/> no <input type="checkbox"/> yes	
Are you concerned about HIV/AIDs or STD exposure? <input type="checkbox"/> no <input type="checkbox"/> yes		Number of meals you eat daily:		Number of times you exercise weekly:		Average number of hours you sleep daily:		Do you wear seatbelts? <input type="checkbox"/> no <input type="checkbox"/> yes	
ARE YOU NOW HAVING SERIOUS PROBLEMS OR STRESS FROM ANY OF THE FOLLOWING?									
<input type="checkbox"/> marriage/relationship		<input type="checkbox"/> children		<input type="checkbox"/> job/finances			<input type="checkbox"/> housing issues		
<input type="checkbox"/> sexual functioning		<input type="checkbox"/> physical/psychological abuse		<input type="checkbox"/> drug/alcohol use			<input type="checkbox"/>		

Please turn over and complete back

PERSONAL HEALTH HISTORY – check boxes for conditions in yourself and family members

	Self	Moth-er	Fath-er	Sib-lings	Childr-en		Self	Moth-er	Fath-er	Sib-lings	Childr-en
Alcoholism/substance abuse						Kidney disease					
Arthritis/joint disease						Liver disease/hepatitis					
Asthma/hay fever/emphysema/lung disease						Mental Health (depression/anxiety/other)					
Blood disorders						Positive PPD/TB					
Bowel/bladder problems						Rheumatic Fever					
Cancer (specify types below)						Seizures/epilepsy					
Dental problems						Sexually transmitted disease					
Diabetes						Sickle cell anemia					
Heart disease/chest pain/heart attack						Stroke					
High blood pressure						Thyroid					

WOMEN ONLY

Indicate number of:	Pregnancies ____	Live births ____	Miscarriages ____	Abortions ____
Have you ever had an abnormal pap? <input type="checkbox"/> no <input type="checkbox"/> yes				
Do you perform a monthly breast self-examination? <input type="checkbox"/> no <input type="checkbox"/> yes				
First day of last menstrual period:			Date of last PAP/vaginal exam:	
Birth control method used if applicable:			Date of last mammogram:	

Signature of patient or responsible party
(for minor patients, this is parent or legal guardian)

Printed name of responsible party if not patient

Legal relationship of responsible party to patient