

ACRC TRIALS

NEW PATIENT INFORMATION FORM

PART I

1. For all household members less than 18 years of age, please provide the necessary contact person information (name, phone number, relationship).
2. If providing a home and work number, please place a in the box where you prefer to be contacted.
3. Please print all information.

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I request that all communications to me by the doctor and staff be handled as follows:

Patient Name : _____

First MI Last

Parent/Guardian Name: _____ Are you the legal guardian? Yes No

First MI Last

DOB: _____ Age: _____ Sex: Male Female

For **WRITTEN** Communication Address to:

Street City State Zip

For **ORAL** Communication Call:

Home: (____) _____ Call here
Mobile: (____) _____ Call here Allow Text Message Carrier: _____
Work: (____) _____ May we leave a message? Yes No

Electronic Mail Communication Address to:

Email : _____

I wish to place the following restrictions on disclosure of my health information:

Please check one: Asian African American Caucasian Hispanic Native

American/American Indian Other: _____

Contact Person (if above is \leq 18 years): _____

Phone: (____) _____

Relationship: _____

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2. MEDICAL HISTORY (Diagnosis)

Please tell me if you have any of the following **diagnoses**, either current or past.

Allergies Have you ever had an allergy skin test? Yes No
If yes, Date of Testing: _____ Physician's Name: _____
Have you ever been on allergy shots? Yes No
Have you had sinusitis? Yes No Frequency: _____

- | | |
|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Headaches, Migraine |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches, Not Migraine |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Arthritis, <input type="checkbox"/> Osteo or <input type="checkbox"/> Rheumatoid | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis, Unspecified | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer (exclude if current) | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcer, Duodenal Ulcer, Gastric |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer, Unspecified |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Colitis/Bowel Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> CNS/Neurologic Chronic Diarrhea |
| <input type="checkbox"/> TB | <input type="checkbox"/> Chicken pox /recent exposure to chickenpox. |
| <input type="checkbox"/> Cataracts (subcapsular) | If immune okay. |

Have you tested positive for: HIV Hepatitis B Hepatitis C
OTHER: _____

3. FAMILY MEDICAL HISTORY

Father: _____ or None
Mother: _____ or None
Paternal
Grand Mother: _____ or None
Grand Father: _____ or None
Maternal
Grand Mother: _____ or None
Grand Father: _____ or None
Siblings: _____ or None
Children: _____ or None

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4. SOCIAL HISTORY

How long have you lived in your current home? _____ years _____ months

Is there any obvious mold problem? Yes No

Type of flooring (include bathroom): _____

History of Smoking: Non-smoker Current smoker Past smoker

If yes, how long? _____ Packs per day: _____

Prolonged cigarette smoke exposure: Yes No

Recreational Drug Use: Yes No

Exercise: Yes No

Caffeine: Yes No Frequency: _____

Married: Yes No Duration: _____

Alcohol: Yes No If yes, type _____ frequency _____

Sexually Transmitted Disease: Yes No If yes, _____

Sexually Active: Yes No

Travel outside US: Yes No

Pets: Dog Cat Other: _____ Indoor Outdoor Both

Occupation _____ **Occup. Exposure:** _____

Have you been hospitalized in the past year? Yes No If yes, Please explain.

History of Surgery or Upcoming Surgeries:

Known **Allergies** to Medications (List names and symptoms):

Are you or do you think you may be pregnant? Yes No

Are you planning or attempting to become pregnant? Yes No

Are you post-menopausal? Yes No If No, what type of birth control are you using to avoid pregnancy? _____

Patient (Guardian) Signature: _____ **Date** _____

Relationship to Patient: _____