GREENVILLE HEALTH SYSTEM
UNIVERSITY MEDICAL GROUP

PATIENT REGISTRATION DEMOGRAPHIC

PATIENT INFORMATION (Please print)

Full Legal Name: ______________________________ Preferred Name: ______________
Last *First* *Middle*

Date of Birth: ______________ SS#: ______________ Sex: ☐ Male ☐ Female
Month/Day/Complete Year

Ethnicity: Hispanic/Latino ☐
Non-Hispanic/Non-Latino ☐
Refused/Declined ☐

Primary Care Physician: ______________________________

Preferred Pharmacy Name: ______________________ Phone Number: ______________

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Life Partner* ☐ *Legally Separated*

Race: ☐ Caucasian (white) ☐ *American Indian* ☐ *African American (black)* ☐ *Hispanic*
☐ Biracial ☐ *Asian Oriental* ☐ Other ☐ *Unknown*

Home Address: ______________________ City______________State________ Zip________

Mail to Address: ______________________ City State Zip

County: ______________ Primary Phone: (   ) ______________ Secondary Phone: (   ) ______________

Preferred language: ______________ E-mail: ______________

Veteran: ___Yes ___No ___Unknown Religion: ______________

GUARANTOR INFORMATION (If guarantor is SELF complete SECTION I only)

Parent/guardian *presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.*

Name: ______________________________ Patient relation to Guarantor : ______________
Last *First* *Middle*

Primary Phone: (   ) ______________

Date of Birth ______________ SS#: ______________ Secondary Phone: (   ) ______________

Home Address: ______________ *(City)* *(State)* *(Zip)* *(Country)*

Mail to Address ***(if different):*** ______________ *(City)* *(State)* *(Zip)* *(Country)*

EMERGENCY CONTACT (Pediatric Patients please list someone other than parent(s)/guardian)

Primary Contact Name: ______________________________ Primary Phone: (   ) ______________

Patient Relation to Emergency Contact ______________________________ Second Phone: (   ) ______________

Secondary Contact Name: ______________________________ Primary Phone: (   ) ______________

Patient Relation to Emergency Contact ______________________________ Second Phone: (   ) ______________

SECTION I

Patient Employer: ______________________________ **Work Phone:(   )** ______________ **Ext:** ______

Address: ______________________________ *(City)* *(State)* *(Zip)*

Employment Status: ☐ ***full-time*** ☐ ***part-time*** ☐ ***self employed*** ☐ ***active military*** ☐ ***student full time***
☐ ***student part-time*** ☐ ***retired date______*** ☐ ***disabled*** ☐ ***not employed*** ☐ ***unknown***

(Pediatric Patients ONLY) PARENT/GUARDIAN & IMMEDIATE FAMILY INFORMATION

MOTHER ***(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)***

Full Name: ______________________________ Nickname: ______________
Last *First* *Middle*

Date of Birth: ______________
Month / Day / Complete Year

SS#: ______________

Home Address: ______________________ City ______________State________Zip________
(if different from patient)

Primary Phone: ______________________ Secondary Phone: (   ) ______________

Employer: ______________________ Work Phone: (   ) ______________Ext__________

FATHER ***(If the address, phone numbers and employer information is the same as guarantor, please indicate same.)***

Full Name: ______________________________ Nickname ______________
Last *First* *Middle*

Date of Birth: ______________
Month / Day / Complete Year

SS#: ______________

Home Address: ______________________ *(City)* *(State)* *(Zip)*
(if different from patient)

Primary Phone: ______________________ Secondary Phone: (   ) ______________

Employer: ______________________ Work Phone: (   ) ______________Ext__________

THIS IS A 2 PAGE DOCUMENT

Patient Name ____________________ DOB ____________________

(Pediatric Patients ONLY) BROTHERS, SISTERS, & OTHER FAMILY MEMBERS

Full Name	M or F	Date of Birth	Relationship	Lives with child
				YES NO
				YES NO
				YES NO
				YES NO

☐ **Check here if NO INSURANCE. Skip to SECTION IV**

ACCIDENT INFORMATION

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ YES ☐ NO

Type of accident: ____________ Date of Accident: ____________ County of accident: ____________

PRIMARY INSURANCE INFORMATION (If subscriber is SELF complete SECTION II only)

SUBSCRIBER INFORMATION (This is the person who carries the insurance)

Subscriber's Name on card: ____________ Date of Birth: ____________
Month/Day/Complete Year

Patient Relationship to Subscriber: ____________ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: ____________ SS#: ____________

City, State, Zip: ____________ Primary Phone: ( )

Employer: ____________ Work Phone: ( ) ____________ Ext:

SECTION II

Insurance Co. Name: ____________ Phone: ( )

CERT# ____________ **Group No:** ____________ Effective Date: ____________

Subscriber Status: ☐ ***full-time*** ☐ ***part-time*** ☐ ***self employed*** ☐ ***active military*** ☐ ***student full time*** ☐ ***student part-time*** ☐ ***retired date*** ____________ ☐ ***disabled*** ☐ ***not employed***

SECONDARY INSURANCE INFORMATION (If subscriber is SELF complete SECTION III only)

SUBSCRIBER INFORMATION (This is the person who carries the insurance)

Subscriber's Name on card: ____________ Date of Birth: ____________
Month/Day/Complete Year

Patient Relationship to Subscriber: ____________ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: ____________ SS#: ____________

City, State, Zip: ____________ Primary Phone: ( )

Employer: ____________ Work Phone: ( ) ____________ Ext:

SECTION III

Insurance Co. Name: ____________ Phone: ( )

CERT# ____________ **Group No:** ____________ Effective Date: ____________

Subscriber Status: ☐ ***full-time*** ☐ ***part-time*** ☐ ***self employed*** ☐ ***active military*** ☐ ***student full time*** ☐ ***student part-time*** ☐ ***retired date*** ____________ ☐ ***disabled*** ☐ ***not employed***

SECTION IV

AUTHORIZATION

I authorize medical evaluation & treatment, and release of information for insurance/medical purpose concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: ____________ **Date:** ____________

Revised:3.21.13

GREENVILLE HEALTH SYSTEM

DISCLOSURE OF MEDICAL INFORMATION

Patient Full Name (PRINT) ____ DOB _________________________

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We cannot discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person	Relationship to Patient
___________________________________	________________________
___________________________________	________________________

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

Home: ____________________________ Work: ________________________________

Cell phone: _________________________ Other: ________________________________

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office. *An automated appointment reminder system will call your home number listed in our data base.*

Name of Person	Phone Number	Relationship to Patient
______________________________	____________________________	________________________
______________________________	____________________________	________________________

Messages: A request for return calls may be left on the following answering machine or voice mail *(check all that apply)*

At home At work On my cell phone I do not authorize

I authorize any medical information regarding myself to be left on the following answering machine or voice mail

(Check all that apply) At home At work On my cell phone I do not authorize

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: ____ Date: _______________

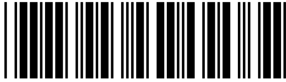
PRINT Name of Personal Representative: ____

Relationship of Representative to Patient: ____

GHS UMG Representative: ____Date: ______________

Note: This restriction applies only to care provided by the Greenville Health System University Medical Group practice identified in the upper left hand corner of this form. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you or UMG may terminate this restriction by completing the following. **The below signature is to be used if you would like to make the above information terminate on a certain date.**

This agreement is terminated as of ______________ Signature ______________________________ *(Date)* _________



Consents/Registration
Greenville Health System

CONSENT AND AUTHORIZATION - UMG

The following are conditions for services provided by the Greenville Health System (GHS) for the above-named patient :

CONSENT AND AUTHORIZATION FOR ROUTINE TREATMENT: I consent to and authorize GHS and my health care providers to provide or order routine health care services, including diagnostic and laboratory procedures that in the judgment of my provider(s), is necessary. Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment. Diagnostic/laboratory procedures that may be ordered could include testing for HIV. I can discuss this with my provider and tell him/her if I do not want to be tested for HIV. If test results are positive, they will be shared with me

PHYSICIANS: I understand that physicians who are members of the GHS medical staff and who practice in GHS facilities may not be employees or agents of GHS. I understand that GHS is not responsible for any act or omission by a physician who is not an employee or agent of GHS. I understand that GHS is a medical teaching institution and that medical students and residents may be involved in my care under the supervision of an attending physician.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: If my account is not paid at the time of my visit, I hereby assign to GHS any and all rights, including proceeds, I may have from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of GHS), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to physician(s) not employed by GHS, any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at GHS (such as anesthesiologists, pathologists, and other private physicians).I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. I understand that I am responsible for any charges not covered by insurance, including Medicare, Medicaid, or any other benefits. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I hereby authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate GHS as my authorized representative and grant to GHS the authority to act on my behalf in pursuing and appealing a benefit determination under the plan, including Medicare and Medicaid. Such authority shall include the right to request and receive a copy and/or summary of the plan description.

FINANCIAL AGREEMENT: I understand that I am obligated to pay my account according to the regular rates and terms of GHS. I hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. If the benefits received by GHS exceed the charges on my account, I authorize GHS to apply the over-payment to my other outstanding account(s) with GHS or GHS entities, which include GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity that is or becomes a part of GHS. If there is no other outstanding account for which I am responsible, I will receive a refund. I understand that GHS may obtain my credit report for review in collection of this account. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

MEDICARE PATIENTS: Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

CONTACTING PATIENTS: I hereby authorize GHS to contact me through the information provided at the time of registration.

DISCLOSURE/USE OF HEALTH INFORMATION: I understand that normal uses and disclosures of my personal and health information are described in the GHS Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

PHOTOGRAPHING: I consent to GHS taking photographs for purposes of identification, diagnosis, treatment, education, and research. Photographs that could identify me will be used only for internal medical record identification purposes unless I specifically agree and sign an additional consent document.

SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE ________________________________

PRINTED NAME AND RELATIONSHIP IF OTHER THAN PATIENT ______________________________________

DATE __________ TIME _______________

SIGNATURE OF WITNESS __________________________ DATE ______________ TIME_____________________

SIGNATURE OF WITNESS __________________________ DATE ______________ TIME _____________________
(SECOND WITNESS FOR TELEPHONE CONSENT OR SIGNATURE WITH "X" OR MARK)

CHART COPY

GREENVILLE HEALTH SYSTEM

FINANCIAL POLICY

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided to the patient by Greenville Health System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Health System University Medical Group or GHS UMG.

Payment for Service: Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

Non-appointment prescription refills: A $15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment prescription: A $25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of medical forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- $.65 per page for the first 30 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $15.00
- Plus actual postage

No-show Appointments: A fee of $25.00 for a follow up visit and $50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

Payment for Services Provided by Certain Non-UMG Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as GHS University Medical Group, you may be billed separately by that service provider. This includes services provided by Greenville Health System.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-885-7989 or 1-888-284-6024 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

HEALTH HISTORY QUESTIONNAIRE – Adult

Questions contained in this questionnaire are strictly confidential and will become part of your medical record.

BASIC INFORMATION	
Patient Name:	Date of Birth:
Last Provider Seen/Date:	
Allergies/Reaction: (☐None)	

PERSONAL HISTORY					
CHILDHOOD ILLNESSES	DATES (*most recent*):	IMMUNIZATIONS	DATES (*most recent*):	HEALTH MAINTENANCE	DATES (*most recent*):
☐ Measles:		☐ Tetanus:		☐ Eye Exam:	
☐ Mumps:		☐ Hepatitis:		☐ EGD:	
☐ Rubella:		☐ Flu:		☐ EKG:	
☐ Chickenpox:		☐ H1N1:		☐ Colposcopy:	
☐ Rheumatic Fever:		☐ Gardasil:		☐ Colonoscopy:	
☐ Polio:		☐ Pneumonia:		☐ Bone Density Screening:	
☐ Other:		☐ Zostavax:		☐ Other:	
☐ Other:		☐ PPD:		☐ Other:	
☐ Other:		☐Other:		☐ Other:	

MEDICAL HISTORY

Please check box labeled **C** *if the problem is* **Current**, *and* **P** *if the problem occurred in the* **Past**.

C	P	RESPIRATORY/ENT	C	P	CARDIOVASCULAR
		Hearing Problems			High Blood Pressure
		Ringing in Ears			Irregular Pulse
		Prolonged Hoarseness			Fainting Spells
		Sinus Trouble			Swollen Ankles
		Vision Problems			Cold Numb Feet
		Bronchitis			Varicose Veins
		Chronic Cough			Dizzy Spells
		Shortness of Breath			Leg Pain/Fatigue
		Eye Pain			Chest Pain/Pressure
		Nose Bleeds			Palpitations
		Sore Throat			Heart Murmur
		Pneumonia	**C**	**P**	EMOTIONAL
		COPD/OSA			Depression
		Asthma			Mental Illness
		Wheezing			Mood Swings
C	**P**	GASTROINTESTINAL			Thoughts of Death
		Appetite			Sleep Problems
		Difficulty Swallowing			Lack of Concentration
		Bloody/Tar-Like Stool			Decreased Work Performance
		Hepatitis			Anxiety
		Nausea/Vomiting			Bipolar
		Bowl Changes	**C**	**P**	URINARY
		Abdominal Pain			>2 Overnight
		Jaundice			Stress Incontinence
		Crohn's Disease			Kidney Stones
		Peptic Ulcer			Blood in Urine
		Gallbladder			Urinary Tract Inf.
		Constipation			Painful
		Diarrhea			Low Flow
		Diverticulosis			Bed Wetting
		Special Diet			

FEMALES ONLY

Menstrual Flow:
☐ Regular ☐ Irregular ☐ Pain/Cramps

Date 1st day of last period:

☐ Flushing/Menopause

Sexually Active: ☐ Yes ☐ No

Sexual Problems: ☐ Yes ☐ No

Birth Control Method:

\# of Pregnancies: # of Miscarriages:

\# of Live Births: # of Abortions:

☐ Vaginal ☐ C-Section

Date of last Pap Smear:

☐ Normal ☐ Abnormal

Date of last Mammogram:

☐ Normal ☐ Abnormal

MALE ONLY

Check all that apply:
☐ Vasectomy ☐ Circumcision ☐ Inguinal Hernia

Sexually Active: ☐ Yes ☐ No

Sexual Problems: ☐ Yes ☐ No

Last PSA date:

Prostate Problems: ☐ Yes ☐ No

Other:

SURGERIES:

Name *(Last, First, M.I.)*:	**DOB:**

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: *(List additional on back)*

Please use the below example when completing the medication section.

Pharmacy name and address
Number used by the drugstore to identify this drug for your refills
Person who gets this drug
Instructions about how often and when to take this drug
Name of drug and strength of drug
Number of refills before certain date
Doctor's name
Drugstore phone number
Prescription fill date

Local Pharmacy
123 MAIN STREET
ANYTOWN, USA 11111
(800) 555-5555
DR C. JONES
NO 0060023-08291
DATE 06/23/09
JANE SMITH
456 MAIN STREET ANYTOWN, US 11111
TAKE ONE CAPSULE BY MOUTH THREE TIMES DAILY FOR 10 DAYS UNTIL ALL TAKEN
AMOXICILLIN 500MG CAPSULES
QTY MRG
NO REFILLS - DR. AUTHORIZATION REQUIRED
USE BEFORE 06/23/12
SLF/SLF
Rx ONLY

Don't use this drug past this date

Medication Name	Dose/Strength	Frequency

Person Completing Form: ______________________________ Date: ____________________

FAMILY HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

BASIC INFORMATION		
Patient Name:	Date of Birth:	Today's date:

FAMILY HISTORY

Please check the box and circle the family member's code that had any of the items listed below.

M=Mother **F**=Father **B**=Brother **S**=Sister **MGF**=Maternal Grandfather **MGM**=Maternal Grandmother **PGF**=Paternal Grandfather **PGM**=Paternal Grandmother

Heart/Cardiovascular		
Angina/Chest Pain/CAD:	☐Y ☐N	M F B S MGF MGM PGF PGM
Heart Attack/Heart Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
High Cholesterol:	☐Y ☐N	M F B S MGF MGM PGF PGM
High Triglycerides:	☐Y ☐N	M F B S MGF MGM PGF PGM
High Blood Pressure:	☐Y ☐N	M F B S MGF MGM PGF PGM
Ischemic Heart Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Sudden Death:	☐Y ☐N	M F B S MGF MGM PGF PGM
PVD/AAA	☐Y ☐N	M F B S MGF MGM PGF PGM
Blockage of Arteries Location(s):____________________	☐Y ☐N	M F B S MGF MGM PGF PGM
Aneurysm:______________	☐Y ☐N	M F B S MGF MGM PGF PGM
Endocrine/Metabolic		
Diabetes Mellitus:	☐Y ☐N	M F B S MGF MGM PGF PGM
Thyroid Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Eyes/Ears/Nose/Throat		
Glaucoma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Hearing Loss:	☐Y ☐N	M F B S MGF MGM PGF PGM
Loss of Vision:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Genetic/Birth		
Birth Defects:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Genitourinary		
Endometriosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Kidney Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Ovary Disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Toxemia of Pregnancy:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Blood/Hematologic		
Clotting Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Anemia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Leukemia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Lymphoma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Hemophilia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Sickle Cell Anemia:	☐Y ☐N	M F B S MGF MGM PGF PGM

Mental Health		
Alcoholism:	☐Y ☐N	M F B S MGF MGM PGF PGM
Attention Deficit Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Bipolar Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Depressive Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Mental Disorder:	☐Y ☐N	M F B S MGF MGM PGF PGM
Schizophrenia:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Musculoskeletal		
Osteoarthritis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Rheumatoid Arthritis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Osteoporosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Multiple Sclerosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Scleroderma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Lupus:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Neurologic		
Alzheimer's disease:	☐Y ☐N	M F B S MGF MGM PGF PGM
Dementia:	☐Y ☐N	M F B S MGF MGM PGF PGM
Migraine:	☐Y ☐N	M F B S MGF MGM PGF PGM
Stroke:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Oncologic		
Melanoma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Ovarian Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
Prostate Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
Skin Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
Stomach Cancer:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM
Respiratory		
Asthma:	☐Y ☐N	M F B S MGF MGM PGF PGM
Pulmonary Embolism:	☐Y ☐N	M F B S MGF MGM PGF PGM
COPD/Emphysema:	☐Y ☐N	M F B S MGF MGM PGF PGM
Cystic Fibrosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
Sleep Apnea:	☐Y ☐N	M F B S MGF MGM PGF PGM
Tuberculosis:	☐Y ☐N	M F B S MGF MGM PGF PGM
☐ Other:		M F B S MGF MGM PGF PGM

Additional Comments: ____

____

Person Completing Form: ____

Today's Date:	
Home # :	
Birth date:	
☐ M ☐ F	

SOCIAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*: ______

Smoking:

Type: ☐ cigarette ☐ cigar ☐ pipe

Start Date:________________

Amount of cigarettes:

☐ less than 1 cigarette/day

☐ light (1-9 cigs/day)

☐ moderate (10-19 cigs/day)

☐ heavy (20-39 cigs/day)

☐ very heavy (40+ cigs/day)

Interested in quitting smoking: ☐ yes ☐ no

STOP DATE: _________________

Smokeless:

Type: ☐ chew ☐ snuff ☐ powder

Start Date:__________________

Amount:___________________

Interested in quitting smokeless:

☐ yes ☐ no

STOP DATE:___________________

Comments:____
____

Alcohol use:

☐ Current alcohol user

☐ Non-drinker

Type: ☐ beer ☐ hard liquor ☐ wine

Average drinks/week:_____________

Drinks/day on typical drinking day:_______

High risk alcohol use: ☐ yes

Binge drinker: ☐ yes

Past heavy use: ☐ yes

Patient has been in an alcohol treatment program: ☐ yes ☐ no

Comments:____
____

Caffeine use:

☐ Uses caffeine

☐ No caffeine use

Type: ☐ coffee ☐ tea ☐ soda

☐ energy drinks ☐ caffeine supplements

Total Amount:

☐ excessive (equiv to 10+ 8oz coffee/day)

☐ heavy (equiv to 4-9 8oz coffee/day)

☐ moderate (equiv to 1-3 8oz coffee/day)

☐ minimal (equiv to < 1 8oz coffee/day)

Comments:____
____

Diet Nutrition:

Difficulty chewing: ☐ yes

Difficulty swallowing: ☐ yes

Hx of eating disorder: ☐ yes

Financial issues affecting the ability to buy the needed food: ☐ yes

Special diet:

☐ diabetic ☐ gluten free ☐ low fat

☐ low sodium ☐ renal ☐ vegan

☐ vegetarian ☐ weight reduction ☐ other

Comments:____
____

Cancer Environmental Risk (other than tobacco:

☐ Has known environmental risk factors for cancer

☐ No known environmental risk factors for cancer

Uses sun protection consistently: ☐ yes ☐ no

Hx of excessive sun exposure: ☐ yes ☐ no

Melanoma high risk: ☐ yes ☐ no

Hx of radiation exposure to neck: ☐ yes ☐ no

Comments:____
____

Home Safety Risk:

☐ Has significant home safety risk factors

☐ No significant home safety risk factors

Abusive home environment: ☐ yes ☐ no

Guns, rifles, or other firearms in home: ☐ yes ☐ no

Seat belt worn consistently: ☐ yes ☐ no

Smoke detectors in home: ☐ yes ☐ no

Child safety seat use: ☐ yes ☐ no

Helmet worn consistently: ☐ yes ☐ no

Fall risk: ☐ yes ☐ no

Knows how to swim: ☐ yes ☐ no

Person Completing Form:____