ESCRIBA MEDICAL GROUP

Name: DOB

Street address:

City/state/zip code:

Phone number:

Email address:

Social security number:

Race Hispanic or Latino

Marital status: single ☐ married: ☐ other: ☐

INSURANCE INFORMATION

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

Emergency contact: _____

Relationship: _____ Phone number

Pharmacy: _____ Address:

Phone Number: Medication Supply Preference: ☐30-day supply ☐90-day supply

MEDICATIONS: Please list all medications, including vitamins, herbals, Over-the-Counter products

NAME	DOSE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY: Please check all that apply**.**

☐ **Anemia**	☐ **Heart Failure**	☐ **High Cholesterol**
☐ **Aortic Aneurysm**	☐ **Heart Valve**	☐ **High Blood Pressure**
☐ **Arrhythmia/Irregular Heartbeat**	☐ **Carotid Artery Disease**	☐ **Kidney Disease**
☐ **Atrial fibrillation (A. fib)**	☐ **Congenital Heart Disease**	☐ **Liver Disease**
☐ **Asthma/COPD/Emphysema**	☐ **Coronary Artery Disease**	☐ **Lupus**
☐ **Blood Clots**	☐ **Dementia**	☐ **Heart Attack**
☐ **Deep Vein Thrombosis (DVT)**	☐ **Diabetes**	☐ **Peripheral Vascular Disease**
☐ **Pulmonary Embolism (PE)**	☐ **GERD**	☐ **Peripheral Artery Disease**
☐ **Bleeding Disorder**	☐ **Gastrointestinal Ulcer**	☐ **Pulmonary Hypertension**
☐ **CVA/Stroke/TIA**	☐ **Rheumatic Fever**	☐ **Sleep Apnea**
☐ **Cancer**	☐ **Seizure Disorder**	☐ **Thyroid Disease**

☐ **Other: _____**

SURGICAL HISTORY: Please list any surgeries or procedures you have had and dates of procedure:

PROCEDURE	DATE
_____	_____
_____	_____
_____	_____

ALLERGIES: Please list all allergies and types of reaction: _____

SOCIAL HISTORY:

Do you consume alcohol? ☐ Yes ☐ No ☐ Former Frequency: _____

Do you smoke/use tobacco? ☐Yes ☐No ☐Former Number of years: _____ Packs per day: _____

Do you use illicit drugs? ☐Yes ☐No ☐Former Substance type: _____

PREVENTIVE HEALTH HISTORY

Please indicate the last time the following were performed (or never):

Eye exam	Podiatrist/Last foot exam
Last stress test	ECG
COLONOSCOPY	Stool Occult Blood Testing
Mammogram:	DEXA Scan (Bone Density):
Influenza vaccine	Tetanus /TDAP vaccine
Pneumovax	Prevnar 13
Hep B vaccine	Hep A vaccine:
Shingles vaccine	

Do you have a living will? Y ☐ N ☐ If so, please provide a copy with our office.

Do you have Do not resuscitate/Do not intubate? Y ☐ N ☐

Signature: Date: