PLEASE PRINT

Date:________/________/________ Home Phone: (______)_______-________

PATIENT INFORMATION

Name:____Social Security:__________________________

Address: ____Cell Phone: (______)_______-_________

City:_________________________________ State:____________________Zip Code:______________________

Sex: M [ ] F [ ] Age:________ Birth Date: ________/________/_________ Race: ______________________

Ethnicity:_________________________ Preferred Language:______________________ Blind: [ ] Deaf: [ ]

☐ Married ☐ Widowed ☐ Single ☐ Divorced

☐ Minor ☐ Separated ☐ Partnered for years

Patient Employer/School: ___________________________________ Occupation:________________________

Employer/School Phone: (______)_______-_________ E-mail: ______________________________________

Whom may we thank for referring you?:____

Emergency Contact:____Phone:(______)_______-_________

PRIMARY INSURANCE

Person Responsible for Account:_____________________________Relation to Patient:___________________

Birth Date:________/________/_________ Social Security #:_______________________________________

Address:____Phone: (______)_______-_________

Person Responsible Employed by:___________________________ Occupation:_________________________

Business Address:______________________________________Business Phone: (______)_______-_________

Insurance Company:____Phone: (______)_______-_________

Member ID:_______________________Group:____________________Subscriber:______________________

Names of other dependents covered under this plan:____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? Yes [ ] No [ ]

Person Responsible for Account:_____________________________Relation to Patient:___________________

Birth Date:________/________/__________Social Security #:_______________________________________

Address:____Phone: (______)_______-_________

Person Responsible Employed by:___________________________ Occupation:_________________________

Insurance Company:____Phone: (______)_______-_________

Member ID:_______________________Group:____________________Subscriber:______________________

Names of other dependents covered under this plan:____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _________________________________

Name of Insurance Company(ies)

and assign directly to Dr.__________________________________. All insurance benefits, if any, otherwise will be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________________________

Signature of Patient, Parent, Guardian or Personal Representative — Date

____ ______________________________

Please print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

Confidential Health History

Patient Name:____Today's Date:________/________/________

Age:__________Birth Date:________/________/_______Date of last physical:________/________/_______

What is your reason for this visit:____

SYMPTOMS

Check conditions you currently have or have had in the past year

General

- [ ] Chills
- [ ] Depression
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Forgetfulness
- [ ] Headache
- [ ] Loss of sleep
- [ ] Loss of weight
- [ ] Nervousness
- [ ] Numbness
- [ ] Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- [ ] Arms
- [ ] Hips
- [ ] Back
- [ ] Legs
- [ ] Feet
- [ ] Neck
- [ ] Hands
- [ ] Shoulders

Genito-Urinary

- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Lack of bladder control
- [ ] Painful urination

Gastrointestinal

- [ ] Poor appetite
- [ ] Bloating
- [ ] Bowel changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive hunger
- [ ] Excessive thirst
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Nausea
- [ ] Rectal bleeding
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Vomiting blood

Cardiovascular

- [ ] Chest pain
- [ ] High blood pressure
- [ ] Irregular heart beat
- [ ] Low blood pressure
- [ ] Poor circulation
- [ ] Rapid heart beat
- [ ] Swelling of ankles
- [ ] Varicose veins

ENT

- [ ] Bleeding gums
- [ ] Blurred vision
- [ ] Crossed eyes
- [ ] Difficulty swallowing
- [ ] Doubled vision
- [ ] Ear ache
- [ ] Ear discharge
- [ ] Hay fever
- [ ] Hoarseness
- [ ] Hearing loss
- [ ] Nose bleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Vision - flashes
- [ ] Vision - halos

Skin

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scars
- [ ] Sores that won't heal

Men Only

- [ ] Breast lump
- [ ] Erectile dysfunction
- [ ] Lump in testes
- [ ] Penis discharge
- [ ] Sore on penis
- [ ] Other

Women only

- [ ] Abnormal pap smear
- [ ] Bleeding between periods
- [ ] Breast lump
- [ ] Menstrual pain
- [ ] Hot flashes
- [ ] Nipples discharge
- [ ] Painful intercourse
- [ ] Vaginal discharge
- [ ] Other

Date of last period:

________/________/________

Date of last pap smear:

________/________/________

Date of last mammogram

________/________/________

Are you pregnant? Y N

Number of children:________

CONDITIONS

Check the conditions you currently have or have had in the past year

- [ ] AIDS
- [ ] Alcoholism
- [ ] Anemia
- [ ] Anorexia
- [ ] Appendicitis
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding disorders
- [ ] Breast lump
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Cataracts
- [ ] Chemical Dependency
- [ ] Chick pox
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Goiter
- [ ] Gonorrhea
- [ ] Gout
- [ ] Heart disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herpes
- [ ] High cholesterol
- [ ] HIV positive
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Measles
- [ ] Migraine headaches
- [ ] Miscarriage
- [ ] Mononucleosis
- [ ] Multiple sclerosis
- [ ] Mumps
- [ ] Pacemaker
- [ ] Pneumonia
- [ ] Polio
- [ ] Prostate problems
- [ ] Psychiatric Care
- [ ] Rheumatic
- [ ] Scarlet fever
- [ ] Stroke
- [ ] Suicide attempt
- [ ] Thyroid problems
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Typhoid fever
- [ ] Ulcers
- [ ] Vaginal infections
- [ ] Venereal disease

Medications: list medications you are currently taking:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? [ ] Yes [ ] No
If yes, please give approximate dates:_______________________

Serious Illnesses/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex	Complications if any

Health Habits

Check which you use and how often

- [ ] Caffeine ____________________
- [ ] Tobacco ____________________
- [ ] Street Drugs____________________
- [ ] Other ____________________

Occupational

Check if your work exposes you to:

- [ ] Stress
- [ ] Hazardous Substances
- [ ] Heavy Lifting
- [ ] Other:______________

Occupation______________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_______________________________________ Signature of Patient, Parent, Guardian or Personal Representative

_______________________ Date

_______________________________________ Please print name of Patient, Parent, Guardian, or Personal Representative

_______________________ Relationship to Patient

Forte Family Practice Health Questionnaire-9 (PHQ-9)

Today's Date:________/________/________

Patient Name:____Date of Birth:________/________/________

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answer:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or or hurting yourself in some way	0	1	2	3

For Office Coding: _______+_______+_______+_______

= Total Score: _______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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