CASTLE PINES
Family Practice | Urgent Care | Sports Medicine

What brings you in today? _____

_____

Patient Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (Apartment #)

_____
(City) State Zip

Date of Birth __/__/__ Sex: _____ Marital Status: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Who is your Primary Care Provider? _____

Where can we best reach you if we have messages to return, lab results or questions?

#: _____

Names and phone numbers of anyone we may communicate results to:

_____

_____

_____

Is it OK to leave results for you at the number above? ☐ Yes | ☐ No

Emergency Contact Info: _____ Phone: _____

Relation to Patient: _____

Employer: _____ Occupation: _____

Work Phone: _____ Extension: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Co-Pay Amount: _____

Group (account) # _____ ID (Member) # _____

Primary Insured Name: _____ SS# _____

DOB: __/__/__ Relationship: _____ Sex: _____

Address if Different from Patient: _____

Employer: _____ Work Phone: _____

Secondary Insurance: _____ Co-Pay Amount: _____

Group (account) # _____ ID (Member) # _____

Primary Insured Name: _____ SS# _____

DOB: __/__/__ Relationship: _____ Sex: _____

Address if Different from Patient: _____

Employer: _____ Work Phone: _____

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Pharmacy (Mail and Local)	Address/Cross Street	Phone Number	Primary
			☐
			☐

Health History Questionnaire

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

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements, or NSAID's. Please include any "as needed" medications.

Name on the Drug	Strength	mg / other Measurement	Frequency Taken	Diagnosis

Allergies to medications

Name the Drug	Reaction You Had

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations & Dates:	☐ Tetanus	☐ Pneumonia - Prevnar 13	☐ Pneumonia - Pneumovax 23
	☐ Hepatitis A	☐ Chickenpox	
	☐ Hepatitis B	☐ Influenza	
	☐ MMR *(Measles, Mumps, Rubella)*	☐ Shingles	

PAST MEDICAL HISTORY (Please check all diagnoses that apply to you and add notes as needed)

☐ None ☐ Abuse/Domestic Violence ☐ ADD/ADHD ☐ Allergic/Immunologic Disorder ☐ Allergies ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Bladder or Kidney ☐ Blood Diseases ☐ Blood Transfusion ☐ Breast Cancer ☐ Cancer (Type_____) ☐ Cardiovascular ☐ Chronic Kidney Disorder	☐ Congestive Heart Failure ☐ COPD/Emphysema ☐ Coronary Artery Disease ☐ Diabetes - Type: _____ ☐ Dialysis – Type: _____ ☐ Disabilities – Type: _____ ☐ Diverticulitis ☐ Endocrine Diseases ☐ ENMT (ear, nose, mouth, throat) issues ☐ Eye Problems ☐ Gastrointestinal/GERD ☐ Genetic/Congenital Condition ☐ Genitourinary ☐ Hematological/Lymphatic	☐ Head Injury / Concussion ☐ Hearing Loss ☐ Hospitalizations ☐ Hepatitis – Type: ☐ HIV ☐ High Cholesterol ☐ High Blood Pressure ☐ Irritable Bowel Syndrome ☐ Kidney Stone ☐ Long-term Steroid Use ☐ Lupus ☐ Macular Degeneration ☐ MI (Heart Attack) – Date: ☐ Motor Vehicle Accident ☐ Musculoskeletal	☐ Neurological ☐ Oxygen use ☐ Obesity ☐ Osteoporosis ☐ Peripheral Artery Disease ☐ Pneumonia ☐ Psychological _____ ☐ Pulmonary ☐ Rheumatoid Arthritis ☐ Seizures/Epilepsy ☐ Skin Conditions _____ ☐ Sleep Apnea ☐ Stroke ☐ Thrombophilia's ☐ Tuberculosis ☐ Ulcers

Signature: _____

Printed Name: _____ Date:_____

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PREVENTATIVE HEALTH SCREENINGS (Please list the date of last testing and results/ additional notes)		
Test	Date	Result/Notes
Bone Density (DEXA)		
Cervical Cancer Screening (Pap Testing)		
Colon Cancer Screening | Type: □ Colonoscopy □ FIT □ FOBT □ Sigmoidoscopy □ Cologuard		
Mammography		
Lung Cancer Screening		
AAA Screening		
Hepatitis C Screening		

SURGICAL HISTORY (Please list surgeries and add any notes as needed)			
Year	Surgery/Procedure	Hospital	Comments or Complications

Have You Ever Had a Blood Transfusion? □ Yes | □ No

HEALTH HABITS AND PERSONAL SAFTEY					
ALL QUESTIONS CONTAINED IN THIS QUESTIONAIRRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL					
Exercise:	□ Sedentary (No Exercise)				
	□ Mild Exercise (climb stairs, walk 3 blocks, golf)				
	□ Occasional Vigorous Exercise (work or recreation, less than 4x/week for 30 min.)				
	□ Regular Vigorous Exercise (work or recreation 4x/week for 30 minutes.)				
Diet:	Are you dieting?				□ Yes | □ No
	If yes, are you on a physician prescribed medical diet?				□ Yes | □ No
	# of meals you eat in an average day?				
	Rank Salt Intake	□ Hi	□ Med	□ Low	
	Rank Fat Intake	□ Hi	□ Med	□ Low	
Caffeine:	□ None	□ Coffee	□ Tea	□ Cola	
	# of cups/cans per day?				
Alcohol:	Do you drink Alcohol?				□ Yes | □ No
	If yes, what kind?				
	How Many Drinks Per Week?				
	Are you concerned about the amount you drink?				□ Yes | □ No
	Have you ever considered stopping?				□ Yes | □ No
	Have you ever experienced blackouts?				□ Yes | □ No
	Are you prone to "binge" drinking?				□ Yes | □ No
	Do you drive after drinking?				□ Yes | □ No
Tobacco	Do you use tobacco?				□ Yes | □ No
	□ Cigarettes – pks. /day	□ Chew – #/day	□ Pipe – #/day	□ Cigars – #/day	
	□ # of Years	□ Or year quit			
Drugs:	Do you currently use recreational or street drugs?				□ Yes | □ No
	Have you ever given yourself street drugs with a needle?				□ Yes | □ No
Sex	Are you sexually active?	□ Never	□ Not Currently	□ Yes	□ Men □ Women
	If yes, are you trying for a pregnancy?				□ Yes | □ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?				□ Yes | □ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				□ Yes | □ No

Signature: _____

Printed Name: _____ Date:_____

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Personal Safety	Do you live alone?	◻ Yes | ◻ No
	Do you have frequent falls?	◻ Yes | ◻ No
	Do you have vision or hearing loss?	◻ Yes | ◻ No
	Do you have an advance directive or living will?	◻ Yes | ◻ No
	Would you like information on the preparation of these?	◻ Yes | ◻ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	◻ Yes | ◻ No

FAMILY HEALTH HISTORY

◻ Are you adopted?

Relationship	Alive	Deceased	Age	No Known Health Problems	Alcohol Abuse	Asthma	Blood Clotting Disorder	Colon Cancer	Prostate Cancer	Breast Cancer	Other Cancer (Specify)	Dementia or Alzheimer's	Mental Illness	Diabetes Type 1	Diabetes Type 2	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Stroke	Thyroid Disease	Other (Specify)	Other (Specify)	Other (Specify)	Other (Specify)
Mother																										
Father																										
Sister																										
Brother																										
Son																										
Daughter																										
Maternal Grandmother																										
Maternal Grandfather																										
Paternal Grandmother																										
Paternal Grandfather																										
Other																										
Other																										
Other																										

Please specify any of the "Other" listed above

Is stress a major problem for you?	◻ Yes | ◻ No
Do you feel depressed?	◻ Yes | ◻ No
Do you panic when stressed?	◻ Yes | ◻ No
Do you have problems with eating or your appetite?	◻ Yes | ◻ No
Do you cry frequently?	◻ Yes | ◻ No
Have you ever seriously thought about hurting yourself?	◻ Yes | ◻ No
Have you ever attempted suicide?	◻ Yes | ◻ No
Do you have trouble sleeping?	◻ Yes | ◻ No
Have you ever been to a counselor?	◻ Yes | ◻ No

Signature: _____

Printed Name: _____ Date:_____

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Additional Information the Provider Should Know:

_____

_____

_____

Please check any symptoms you are currently having:

Please notify a staff member if you are having any COVID-19 symptoms or have been exposed to someone who has been diagnosed with COVID-19. If you have chronic ongoing issues, and you know your symptoms are not related please let us know as well.

GENERAL:
- ❑ **Fever**
- ❑ **Chills**
- ❑ **Sweating**
- ❑ **Appetite Change**

EYES:
- ❑ **Eye Redness**
- ❑ **Eye Pain**
- ❑ **Eye Discharge**
- ❑ **Vision Changes**
- ❑ **Sensitivity to Light**

EAR/NOSE/THROAT:
- ❑ **Runny Nose**
- ❑ **Sore Throat**
- ❑ **Sinus Pain/Pressure**
- ❑ **Congestion**
- ❑ **Ear Pain**
- ❑ **Ear Discharge**
- ❑ **Hearing Loss**
- ❑ **Sensitivity to Sound**

RESPIRATORY:
- ❑ **Cough**
- ❑ **Shortness of Breath**
- ❑ **Wheezing**

CARDIOVASCULAR:
- ❑ **Chest Pain/Tightness**
- ❑ **Leg Swelling**
- ❑ **Palpitations (Irregular Heart Beat)**
- ❑ **Fainting**

GASTROINTESTINAL:
- ❑ **Abdominal Pain**
- ❑ **Nausea**
- ❑ **Vomiting**
- ❑ **Diarrhea**
- ❑ **Constipation**

GENITOURINARY:
- ❑ **Painful Urination**
- ❑ **Urinary Frequency (More Than Usual)**
- ❑ **Blood in Urine**
- ❑ **Vaginal Bleeding**
- ❑ **Vaginal Discharge**
- ❑ **Scrotal Pain**
- ❑ **Scrotal Swelling**
- ❑ **Penile Discharge**

MUSCULOSKELETAL:
- ❑ **Joint Pain**
- ❑ **Back Pain**
- ❑ **Joint Swelling**
- ❑ **Neck Pain**

SKIN:
- ❑ **Color Change**
- ❑ **Rash**
- ❑ **Wound**

NEUROLOGIC:
- ❑ **Dizziness**
- ❑ **Headache**
- ❑ **Numbness/Tingling**
- ❑ **Weakness**

HEMATOLOGIC:
- ❑ **Swollen Glands**
- ❑ **Easy Bruising/Bleeding**

BEHAVIORAL:
- ❑ **Confusion**
- ❑ **Decreased Concentration**
- ❑ **Depression**
- ❑ **Anxiety**
- ❑ **Sleep Disturbance**

Signature: _____

Printed Name: _____ Date:_____

OTHER CONCERNS
Please use the space below to share any other concerns.

Billing Procedure

I authorize the release of any information necessary to process claims. I request payment of benefits to Castle Pines Family Practice. I understand I am financially responsible for any charges not covered by this authorization. I agree to pay for charges that are not covered by my insurance coverage.

Signature _____ Date: __/__/__ Relationship to Patient _____

Consent for Care of Minors

My son/daughter is a minor (less than 18 years of age primarily supported by a parent or guardian), I understand and agree that he/she may be evaluated and/or treated by Castle Pines Family Practice and staff if I am not present to give consent. This may include but not necessarily be limited to physical exam, blood and urine tests, injections, and the prescription medications in my absence.

Signature _____ Date: __/__/__ Relationship to Patient _____

Signature: _____

Printed Name: _____ Date:_____