Castle Pines Family Practice

PATIENT INFORMATION

Name:_____ SSN: _____
Last First MI

Sex: ☐ M ☐ F DOB:_____ Preferred Name: _____

Address:_____

_____
City State Zip

Mailing address: ☐ Check if same as above

_____
Address

_____
City State Zip

Home Phone:_____ Cell:_____

Religion: _____ ☐ Declined Birthplace: _____

Ethnicity: Do you consider yourself to be Hispanic or Latino? ☐ Yes ☐ No ☐ Declined

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ White
☐ Black or African American ☐ Asian ☐ Declined

PHARMACY	**Address/Cross Streets**	**Phone Number**	**Preferred**
Local:			☐
Alternative:			☐
Mail Order:			☐

CARE TEAM

Primary Care Provider:_____ Phone Number: _____

Specialist Name:_____ Specialty:_____ Phone Number: _____

Specialist Name:_____ Specialty:_____ Phone Number: _____

EMERGENCY CONTACT

Name:_____ Relation to patient: _____
Last First

Address:_____

Phone:_____ Legal Guardian: ☐ Yes ☐ No

Name:_____ Relation to patient: _____
Last First

Address:_____

Phone:_____ Legal Guardian: ☐ Yes ☐ No

Castle Pines Family Practice

SUBSCRIBER INFORMATION

Name:_____ DOB:_____
Last First mm/dd/yy

Address:_____

_____
City State Zip

Phone: _____

SSN:_____ Relation to patient:_____

Employer:_____ Full Time/Part Time: _____

Chief Complaint (Reason for Visit): _____

ALLERGIES ☐ No Known Drug Allergies

Medication:_____ Reaction:_____

Medication:_____ Reaction:_____

Medication:_____ Reaction:_____

Other (latex, adhesive, food, environment): _____

Other (latex, adhesive, food, environment): _____

MEDICATIONS ☐ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

PATIENT INFORMATION

Name:_____ DOB: _____
Last First MI

BIRTH HISTORY

Hospital of Delivery? _____
(Name) (City, State/Zip)

Birth Weight:_____ **Weeks Pregnant** (Gestational age): _____

Complications with Pregnancy/Delivery/Hospital Stay? ☐ Yes ☐ No

Explain if ✓ **Yes:** _____

Hearing Screen passed in hospital? ☐ Yes ☐ No ☐ Don't Know

PERSONAL MEDICAL HISTORY

Please check all diagnoses that apply to you and add notes as needed.

AIDS	☐ Yes	☐ No	Oxygen Use	☐ Yes	☐ No
Anemia, Type:_____	☐ Yes	☐ No	Pneumonia, recurrent	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Bleeding / Clotting disorder	☐ Yes	☐ No	Seasonal Allergies: _____	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No	Seizures, Type:_____	☐ Yes	☐ No
Congenitial	☐ Yes	☐ No	Snoring	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Throat infection, recurrent	☐ Yes	☐ No
Diabetes, Type: _____	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Disabilities:_____	☐ Yes	☐ No	Tuberculosis exposure	☐ Yes	☐ No
Ear Infection, recurrent	☐ Yes	☐ No	UTI (Bladder infections)	☐ Yes	☐ No
Environmental/Food Allergies: _____	☐ Yes	☐ No	Other Conditions:_____	☐ Yes	☐ No
GERD (Reflux)	☐ Yes	☐ No	_____		
Head Injury/Concussion	☐ Yes	☐ No	_____		
Hearing Deficit	☐ Yes	☐ No	_____		
HIV	☐ Yes	☐ No	Date of last dental exam: _____		
Long-Term Steroid Use	☐ Yes	☐ No	Date of last vision exam: _____		

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Last First MI mm/dd/yyyy

SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed.

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

Have you ever had a reaction to general anesthesia? ☐ Yes ☐ No

Additional Personal Medical History

_____

_____

_____

_____

_____

_____

_____

_____

Tobacco Use: ☐ Second hand smoke exposure ☐ No second hand smoke exposure

SOCIAL HISTORY (Complete for current age)

Diet: (0-24 months)

Breastfed: ☐ Yes ☐ No

Vitamin Supplement: ☐ Yes ☐ No

Formula: ☐ Yes ☐ No

Diet: (24 months-11 years)

☐ Breastfed ☐ Age Appropriate ☐ Vegetarian ☐ High Fat/Calorie Intake ☐ Other

Exercise/Activity Level: ☐ Sedentary ☐ Strength/Wt. Training ☐ Active

☐ Twenty minutes/day exercise ☐ Exercise three times weekly ☐ Aerobic/Cardiac

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Name: _____ DOB: _____
Last First MI mm/dd/yyyy

With whom do you live? ☐ Mom ☐ Dad ☐ Both Parents ☐ Sibling ☐ Other: _____

Education: ☐ Day Care (name): _____ ☐ Grade School: (current grade) _____

In the last 30 days, have you traveled to any foreign countries? ☐ Yes ☐ No List: _____

Do you: ☐ Use seatbelts ☐ Use a helmet ☐ Have guns in home ☐ Have smoke detector in home ☐ Car Seat/Booster

Concerns about learning or development skills (specify): _____

Concerns about behavior or social skills (specify): _____

How many hours of screen time/day: _____

IMMUNIZATIONS

☐ All Immunizations current ☐ Unknown

Please provide any known dates or full immunization record(s).

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION

Name: _____ DOB: _____
Last First MI mm/dd/yyyy

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes below, if known.

Relationship	Name	Status	No Known Problems	Alcohol abuse	Asthma	Blood clots	Breast cancer	Colon cancer	Prostate cancer	Other cancer(s)	Dementia	Diabetes	Heart disease	High blood pressure	High cholesterol	Kidney disease	Liver disease	Lung disease	Mental Illness	Ovarian Cancer	Stroke	Thyroid condition(s)	Other:_____	Other:_____	Other:_____
Mother		☐ Alive ☐ Deceased																							
Father		☐ Alive ☐ Deceased																							
Sister		☐ Alive ☐ Deceased																							
Brother		☐ Alive ☐ Deceased																							
Son		☐ Alive ☐ Deceased																							
Daughter		☐ Alive ☐ Deceased																							
Maternal Grandmother		☐ Alive ☐ Deceased																							
Maternal Grandfather		☐ Alive ☐ Deceased																							
Paternal Grandmother		☐ Alive ☐ Deceased																							
Paternal Grandfather		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							

Are you adopted?: ☐ Yes ☐ No

Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS**:

General/ Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Diaphoresis (Sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Irritability
- ☐ Unexpected Weight Change

Ear, Nose & Throat
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia (Sensitivity to Light)
- ☐ Visual Disturbance (Blurred Vision)

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Airway Obstruction)
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations (Irregular Heart Beat)

Gastrointestinal
- ☐ Abdominal Distention (Bloating)
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Abnormal Thirst)
- ☐ Polyphagia (Abnormal Hunger)
- ☐ Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Swelling
- ☐ Myalgias (Muscle Pain)
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Pallor (Paleness)
- ☐ Rash
- ☐ Wounds

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurologic
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headache(s)
- ☐ Light Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Loss of Consciousness)
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy (Swollen Glands)
- ☐ Bruising Tendency
- ☐ Bleeding Tendency

Behavioral
- ☐ Agitation
- ☐ Behavioral Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Mood Changes)
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervousness
- ☐ Anxiety
- ☐ Self Injury
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts

Any other symptoms: _____

_____

Patient or Guardian Name (please print)	Patient or Guardian Signature	Date