Express HEALTH Clinic – New Patient Information Form

Ver 20.0

****NOTE- If you have a condition that is outside this clinic's offered services, you may be referred elsewhere for further evaluation.**
****NOTE- It is important that you read the signage posted in the clinic for additional information related to your visit to our clinic.**

Today's Date	Insurance Name:	☐ Self-Pay

SECTION 1 PATIENT INFORMATION

Patient Full Legal Name (First) (Middle) (Last)	Date of Birth	SSN	Sex ☐ Male ☐ Female

Address (Number) (Street) (Apt. No.)				
City	State	Zip	Phone (Home)	Phone (Cell)
Primary Care Physician	Marital Status		Employment Status	Student Status
Emergency Contact Name ('ER Contact')	Relationship:	Contact Phone	Circle information that may be shared with ER Contact: All Medical Financial None	

Other Adults allowed to bring minor child for treatment:

Have you Executed an Advanced Directive such as "Living Will" or Power of Attorney? ☐ NO ☐ YES – Please provide a copy

The Following Responsible Party is the "Guarantor" and is responsible for the cost of services to the Patient:

Full Legal Name	Date of Birth:	Social Security No		Relationship to Patient	
Address (if different than Patient):	City	State	Zip	Phone (Home)	Phone (Cell)

The following Information is regarding the Insurance cardholder if other than Patient or Responsible Party:

Full Legal Name	Date of Birth	Social Security Number

SECTION 2: MEDICAL HISTORY – Conditions you have or have had in the past – check all that apply

High Blood Pressure		Allergies/"Hay Fever"		Diabetes		Cancer		Prostate enlargement	
Heart Attack		Frequent Ear Infection		Kidney Disease		Stroke		Glaucoma	
Heart Disease		Frequent Sinus Infection		Liver Disease		Seizures		Depression/Anxiety	
Heart Murmur		Asthma		High Cholesterol		Emphysema/COPD		Low Thyroid	

Hospitalizations (*list dates*):	Surgeries (*list dates*):

Current Medications ☐ None ☐ Yes – list:	Medical Allergies ☐ None ☐ Yes – list:

Other:	Smoker: ☐ No ☐ Prev ☐ Yes: Packs/Day: # Years: Second Hand Smoke exposure: ☐ No ☐ Yes	Are you pregnant or breast feeding?:

SECTION 3: REASON FOR VISIT – Check Each Box That Applies

☐ **Medication Refill**	☐ **Physical Exam** - Sports School Work	Employer?
☐ **Suture Removal**	☐ **Drug Screen** - DOT Employment Other	Employer?
☐ **Illness or Injury**	**The Reason for my visit, or my "Chief Complaint", and its Symptoms are:**	**When did Problem Start:**

Please answer ALL of the following questions "yes/no" related to your illness or injury

Nose congestion:	☐ Yes	☐ No	Ear Problem:	☐ Yes	☐ No	Skin condition/rash:	☐ Yes	☐ No
Postnasal Drip:	☐ Yes	☐ No	Eye problem:	☐ Yes	☐ No	Urinary Problem:	☐ Yes	☐ No
Sinus Pressure/Pain:	☐ Yes	☐ No	Fever:	☐ Yes	☐ No	Rapid/irregular heart rate	☐ Yes	☐ No
Yellow or green mucous	☐ Yes	☐ No	More tired than usual:	☐ Yes	☐ No	Swelling in legs:	☐ Yes	☐ No
Headache:	☐ Yes	☐ No	Muscle/joint aches:	☐ Yes	☐ No	Emotional problem:	☐ Yes	☐ No
Allergies flared up:	☐ Yes	☐ No	Poor Appetite:	☐ Yes	☐ No	Trouble sleeping:	☐ Yes	☐ No
Cough:	☐ Yes	☐ No	Nausea:	☐ Yes	☐ No	Bleeding problems:	☐ Yes	☐ No
Chest tightness:	☐ Yes	☐ No	Vomiting:	☐ Yes	☐ No	Swollen lymph nodes:	☐ Yes	☐ No
Wheezing:	☐ Yes	☐ No	Diarrhea:	☐ Yes	☐ No	Elevated blood sugars:	☐ Yes	☐ No
Shortness of Breath:	☐ Yes	☐ No	Constipation:	☐ Yes	☐ No	Alcohol Use:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No	Heartburn:	☐ Yes	☐ No	Recreational Drug Use	☐ Yes	☐ No
Sore/Swollen/Bleeding Gums:	☐ Yes	☐ No	Jaw Pain:	☐ Yes	☐ No	Other:		

Have you had any steroids, injected or oral, in the in the last 30 days? ☐ No ☐ Yes - *Dates:*

Have you traveled outside of the united states in the in the last 30 days? ☐ No ☐ Yes - *Dates:*

Please turn form over. Read, Complete, Sign and Date.

Reviewed By: ,FNP

PLEASE NOTE *Strep Tests will not be valid if you have had food, drink, gum, lozenges or cigarettes within 15 minutes before test.*