Hudson's Bay Medical Group Inc. P.S.

Patient Information: Provider: KB/ AK

First Name_____ MI_____ Last Name_____
Mailing Address_____ City _____State _____Zip _____
Home Phone _____ Cell Phone _____ Preferred(circle one): Home/Cell
Date of Birth_____Male/Female/Other_____SSN_____
Place of Birth: _____ Race/Nationality: _____ Ethnicity: _____
Primary Language _____ E-Mail Address: _____
Married/Single/ Divorced/Widowed/Domestic Partner Social: Alone/ Family/ Assisted Living/Other: _____
Religion: _____ Education: _____ Occupation: _____
Spouse/Partner's Name: _____ Phone Number: _____
Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
Previous Doctor _____ Phone Number: _____
Insurance Information Primary:
Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Relationship to Patient: _____
Insurance Information Secondary:
Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Relationship to Patient: _____

Medical Information:

Alcoholic Beverages: Now/ Past/ Never
Recreational Drugs: Now/ Past/ Never
Tobacco Use: Now/ Past/ Never
Secondhand Smoke: Now/ Past/ Never

Immunization Dates:
Tetanus (TD, DPT): _____ Hepatitis A: _____ Hepatitis B: _____ MMR: _____
Pneumonia: _____ Shingles: _____ Tuberculosis Skin (TB): _____

Surgeries: Have you had the following surgeries (R=Right, L=Left, B=Both)?

Surgery:	Date:	Surgery:	Date:
Appendectomy:	_____	Hernia: Location	_____
Back Surgery:	_____	Hysterectomy:	_____
Neck:	_____	Abdominal _____ Vaginal _____	
Low Back:	_____	Ovaries left in Y/ N Ovaries out: R / L / B	
Breast Biopsy: R / L / B	_____	Tubal Ligation	_____
Breast Implant: R / L / B	_____	Joint/Bone Surgery:	_____
Mastectomy: R / L / B	_____	Location _____ Side: R / L / B	
Carotid Artery Surgery:	_____	Prostate Surgery:	_____

Surgery (cont.):	Date:	Surgery:	Date:
Cataracts: R / L / B	_____	Abdominal _____	Urethral _____
LASIK Eye Surgery: R /L /B	_____	Tonsillectomy:	_____
Gallbladder-Type: Laparoscopic or open		Vasectomy:	_____
Other Surgeries:	_____		

Procedure Dates:

Colonoscopy: _____ Mammogram: _____ DRE: _____
(diabetic retinal exam)

Family Medical History: **** Has anyone in your family had? For Aunts/Uncle/Grandparents, Please indicate if they are Mother or Father's side, and age when they got the disease. ****

Disease:	Family Member:	Disease:	Family Member:
Cancer:		Coronary Artery Disease/Heart Disease:	
Breast	_____		_____
Colon	_____	Kidney Disease:	_____
Ovary	_____	Depression:	_____
Prostate	_____	Anxiety:	_____
Other	_____	Alcoholism:	_____
Colon Polyps:	_____	Thyroid Disease:	_____
Diabetes:	_____	Type:	_____
High Blood Pressure:	_____	Alzheimer's Disease:	_____
High Cholesterol:	_____	Migraines:	_____
Stroke:	_____	Other: _____	_____

Past Medical History: Please circle if you Have Had or Have any of the following disorders/diagnoses (indicate on the line P=Past or C=Current)

_____ ADD/ADHD
_____ Alcoholism
_____ Allergies: Pollen/ Cats/ Dogs
Dust Mites/ Others: _____
_____ Allergic Rhinitis
_____ Anemia
_____ Anxiety
_____ Arthritis: Degenerative/Osteoarthritis:
What Joint: _____
_____ Asthma
_____ Atrial Fibrillation
_____ Bee Sting Allergy
_____ Bipolar Disorder
_____ Cancer: Type: _____
_____ Colitis: Type: _____
_____ Headaches
_____ High Blood Pressure (Hypertension)
_____ High Cholesterol/Lipids (Hyperlipidemia)
_____ Transient Ischemic Attack
_____ Incontinence
_____ Irritable Bowel Syndrome:
Symptom: Diarrhea/Constipation/Pain
_____ Insomnia
_____ Kidney Stones
_____ Kidney Disease
_____ Liver Disease
_____ Low Back Pain
_____ Migraine
_____ Neck
_____ Peripheral Artery Disease

_____ Coronary Artery Disease
_____ Congestive Heart Failure
_____ Colon Polyps
_____ Constipation
_____ COPD/ Emphysema
_____ Dementia
_____ Depression
_____ Diabetes: Type: _____
_____ Erectile Dysfunction
_____ Fibromyalgia
_____ GERD/Heartburn
_____ Gout
Other Diagnoses: _____

_____ Prostate Enlargement
_____ Psoriasis
_____ Pulmonary Embolism
_____ Restless Leg Syndrome
_____ Rosacea
_____ Seizure Disorder
_____ Sleep Apnea
_____ Stroke/TIA
_____ Thyroid Disorder
Overactive/Underactive
_____ Tremors
_____ Ulcer: Where: _____
_____ Vein Clot

Children (List Sex/Birth Year): _____
_____

Medications: Please list all prescription and nonprescription medications

Medications:	Dosage/Instruction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies:	Reaction:
_____	_____
_____	_____
_____	_____

Pharmacy Name: _____ Address: _____
Phone: _____ Fax: _____

I certify the above information given by me is correct and true.

Patient Name (PRINT) _____ Date _____

Patient or Legal Representative Signature _____ Relationship _____

Phone Messages: It is our policy to leave brief messages regarding lab results, imaging results and appointment dates and times. We do not leave messages for abnormal results: Initial for consent_____.