Pak Medical Group

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PATIENT QUESTIONNAIRE

Please fill out this form as thoroughly as possible, printing all responses clearly. All information contained in these pages is completely confidential and will not be released unless you authorize us to do so.

PERSONAL INFORMATION **Please provide a form of identification (Driver's License)						
Last Name	First	Middle	Prefix	Birthdate	Sex	
					M	F
Mailing Address	City	State	Zip	Social Security Number		
Home/Mobile Phone	Email Address					
Emergency Contact	Relationship	Home/Mobile Phone	Work Phone			
INSURANCE INFORMATION IF DIFFERENT FROM ABOVE **Please provide a copy of the Insurance Card(s)						
Name of Person Responsible for Insurance Account:		Relation to Patient:				
Birthdate:	Soc. Sec. Number:	Insurance Company(ies)				
Address (if different from patient's):						

MEDICAL HISTORY *Check ☑ conditions you have or have had in the past.*			
❑ Alcoholism	❑ Chemical dependence	❑ Hepatitis	❑ Psychiatric care
❑ Anemia	❑ Depression	❑ Herpes	❑ Rheumatic fever
❑ Anxiety	❑ Diabetes	❑ High blood pressure	❑ Seasonal allergies
❑ Arthritis	❑ Eating disorder	❑ High cholesterol	❑ Sexual difficulty
❑ Asthma	❑ Emphysema/COPD	❑ HIV/AIDS	❑ Sexually transmitted infection
❑ Autoimmune disease	❑ Epilepsy/Seizures	❑ Kidney disease	❑ Skin rash
❑ Bleeding/Clotting disorder	❑ Erectile dysfunction	❑ Liver disease	❑ Sleep apnea
❑ Bone/Joint disorder	❑ GERD (reflux)	❑ Multiple sclerosis	❑ Stroke
❑ Breast lump	❑ Goiter	❑ Osteoporosis	❑ Thyroid problem
❑ Cancer *(see below)*	❑ Gout	❑ Peripheral vascular disease	❑ Tuberculosis
❑ Congestive heart failure	❑ Headaches	❑ PPD positive	❑ Urinary incontinence
❑ CAD/Heart disease	❑ Heart attack	❑ Prostate problem	❑ Vaginal infection
❑ Other (*Please describe)*			
If you have/had cancer, please name type(s) and describe treatment with corresponding dates in the space below.			

Date of last physical exam:	Former primary care provider:
Reason for today's visit	
Please describe any symptoms/complaints that you would like to discuss with your primary care provider at today's appointment.	

Patient Name_____ Date of Birth_____ Today's Date_____

ALLERGIES	
No Known Allergies	Yes, I have the following medication and/or food allergies. Please describe your reaction to each medication/food listed.

HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES, SURGERIES

YEAR	LOCATION	REASON FOR HOSPITALIZATION / DESCRIBE SERIOUS ILLNESS OR INJURY

MEDICATIONS List all medications, including over-the-counter medications and supplements. Write dosage and frequency for each medication. *Please attach additional sheets if necessary.

Preferred Pharmacy & Address:	Phone:
Secondary Pharmacy & Address:	Phone:

Health Maintenance History Record last date and result:

Colonoscopy:	Cardiac Testing:
Mammogram:	Abdominal US:
Bone Density Testing:	Eye exam:
Pap Smear or Prostate Exam:	Pneumovax23: Prevnar13:
Low Dose CT Lung:	Influenza Vaccine:

Family Medical History

Relation	Age at Death	Medical Condition(s)
Father		
Mother		
Brother(s)		
Sister (s)		
Other		

Health Habits Mark (**X**) conditions you use and how much:

				Occupation
	Tobacco use:		Alcohol use:	Description:
	Illegal drug use:		Other:	

Patient Name_____ Date of Birth_____ Today's Date_____

**** Please review our Clinical Policies and Agreements****

Your signature below signifies that you have read and acknowledge the policies regarding:

1) Consent for Treatment
2) Financial Responsibility
3) Release of Information
4) Benefit Assignment
5) About Physician Assistants
6) Acknowledgement
7) Notice of Privacy Practices

I attest that the above information is correct to the best of my knowledge.

I also certify that I, and/or my dependent(s), have insurance coverage with the insurance(s) provided and assign all insurance benefits, if any, directly to Pak Medical Group, PLLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The clincians assigned to Pak Medical Group 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 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

_____

Printed name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient