PATIENT REGISTRATION

PATIENT INFORMATION: (PLEASE PRINT)

NAME: _____ _____ _____ SEX: ☐ Male ☐ Female
Last First M.I.

ADDRESS: _____ _____ _____ _____
Street City State Zip Code + 4 Digits

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

HOME PHONE: _____ CELL PHONE: _____ FAX: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

RACE: ☐ African American ☐ Asian ☐ Caucasian ☐ Other: _____ ☐ Hispanic ☐ Non-Hispanic

OCCUPATION: _____ WORK PHONE: _____

EMPLOYER: _____

PRIMARY PHYSICIAN: _____

EMERGENCY CONTACT INFORMATION:

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

RELATIONSHIP: _____ HOME PHONE: _____ WORK PHONE: _____

RESPONSIBLE PARTY INFORMATION: (IF OTHER THAN THE PATIENT)

NAME: _____ _____ _____ RELATIONSHIP: _____
Last First M.I.

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

HOME PHONE: _____ CELL PHONE: _____ FAX: _____

EMPLOYER: _____ WORK PHONE: _____

West Allis Primary Care Physicians, SC

Your Privacy is Important to Us

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

West Allis Primary Care Physicians, S.C. (WAPCP) is required by law to maintain the privacy of your personal health information and to provide you with this notice describing WAPCP's legal duties and privacy practices concerning your personal health information. In general, when WAPCP uses or discloses your health information, WAPCP is obligated to use or disclose the minimum amount of information necessary to achieve the purpose of disclosure. However, this minimum necessary rule does not apply if disclosure is to a provider regarding your treatment, to you, or due to a legal requirement. WAPCP is required to abide by the privacy practices described in this notice.

However, WAPCP reserves the right to change the privacy practices described in this notice, in accordance with the law. Changes to WAPCP's privacy practices would apply to all health information maintained by WAPCP. If WAPCP changes its privacy practices, WAPCP will furnish you with a revised copy of its privacy notice, which will be made available at the office.

With your written consent, WAPCP can use your health information for the following purposes:

1. ***Treatment.*** For example, a physician may use the information in your medical record to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.
2. ***Payment.*** In order for an insurance company or other health insurer to pay for your treatment, WAPCP needs to submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, with your written consent, WAPCP will pass such health information onto an insurer in order to help receive payment for your medical bills.
3. ***Health Care Operations***. WAPCP may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care delivered by WAPCP. These quality and cost improvement activities may include evaluating the performance of your physicians, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to similarly situated patients.

Without your written authorization, WACPC can use your health information for the following purposes:

1. ***As required by law.*** In certain circumstances, WAPCP may have to report some of your health information to legal entities, such as law enforcement officials, court officials, or government agencies. Examples of such circumstances may be to report abuse, neglect, domestic violence, or certain physical injuries, or to respond to a court order.
2. ***For public health activities.*** WAPCP may be required to report your health information to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information related to the jurisdiction of the Food and Drug Administration, or information related to child abuse or neglect. WAPCP may also have to report certain work-related illnesses and injuries to your employer so that workplace medical surveillance activities can be conducted.
3. ***For health oversight activities.*** WAPCP may disclose your health information to authorities for audit, investigation, inspection, licensure, disciplinary or other purposes related to oversight of the health care system or government benefit programs.
4. ***For activities related to death.*** WAPCP may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying your body, determining cause of death, or in the case of funeral directors, to carry our funeral preparation activities.
5. ***For organ or tissue donation.*** WAPCP may disclose your health information to entities involved in obtaining, banking or transplanting organs for donation or transplantation purposes.
6. ***For research.*** Under certain circumstances, and only after a special approval process, WAPCP may use and disclose your health information to help conduct research. Such research might involve studies related to evaluating the effectiveness of a treatment.
7. ***To avoid a serious threat to health or safety.*** As required by law and standards of ethical conduct, WAPCP may use or disclose your health information to the necessary authorities if WAPCP believes, in good faith that such use or disclosure is necessary to prevent or minimize a serious and imminent threat to your or the public's health or safety.
8. ***For military, national security, or incarceration/law enforcement custody***. If you are involved with the military, national security or intelligence activities, or you are in the custody of lawn enforcement officials or an inmate in a correctional institution, WAPCP may disclose your health information to the proper authorities so they may carry out their duties under the law.

9. ***For workers' compensation.*** WAPCP may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illnesses.
10. ***WAPCP Directory.*** Unless you object, WAPCP may use your health information, such as your name, your general health, and your religious affiliation for a directory. The information about you contained in the directory will be disclosed to people who ask for you by name. However, the information about your religious affiliation will only be disclosed to clergy. WAPCP may allow you to object or agree orally regarding the use of your health information for directory purposes.
11. ***To those involved with your care or payment of your care.*** If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, WAPCP may disclose relevant health information about you to those people. The information disclosed to these people may include your general condition, or death. You have the right to object to such disclosure, unless you are incapacitated or there is an emergency. WAPCP may disclose your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your health status. WAPCP may allow you to object or agree orally to such disclosure, unless there is an emergency.

Note: Except for the situations listed above, any other use or disclosure of your health information requires WAPCP to obtain your written authorization. You may wish to withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit written withdrawal to 12555 W. National Avenue, #201, New Berlin, WI 53151.

Your Health Information Rights

You have several rights with regard to your health information. Specifically, you have the right to:

1. Request restrictions on certain uses and disclosures. You have the right to notify WAPCP that you want restrictions placed on how your health information is used or to whom your information is disclosed, even if the restrictions affects your treatment or WAPCP's payment or health care operation activities. Or, you may want to restrict health information provided to family or friends involved in your care or payment of medical bills. You may also want to restrict the health information provided to authorities involved with disaster relief efforts. However, it should be noted that WAPCP is not required to agree in all circumstances to your requested restriction.
2. As applicable, receive confidential communication of health information. You have the right to request alternative means or locations when WAPCP communicates your health information to you. WAPCP must accommodate reasonable requests.
3. To inspect and copy your health information. With few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information compiled for judicial proceedings. In addition, WAPCP, may charge you a reasonable fee if you want a copy of your health information.
4. To amend the information. If you believe your health information is incorrect, you may ask WAPCP to amend the information. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if WAPCP disagrees with you and does believe your health information is correct, WAPCP may deny your request.
5. To receive an accounting of disclosures of your health information. In some limited instances, you have the right to request an accounting of the disclosures of your health information WAPCP has made during the previous six years, but the request cannot include dates before April 14, 2003. This accounting must include the date of each disclosure, who received health information, a brief description of the health information disclosed, and why the disclosure was made. WAPCP must comply with your request for an accounting within 30 days, unless you agree to a 30 day extension, and WAPCP may not charge you for the accounting unless you request such an accounting more than once per year. In addition, WAPCP will not include in the accounting disclosures made to you, or for purposes of treatment, payment, health care operations, national security, law enforcement/corrections, and certain health oversight activities.
6. To obtain a paper copy of this notice. Upon request, you may receive a paper copy of this notice.
7. To complain. If you believe your privacy rights have been violated, you may file a complaint with WAPCP and with the Federal Department of Health and Human Services. WAPCP will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact Cathy Halvorsen, who will provide you with the necessary assistance and paperwork.

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact our office at (262) 754-8005.

WEST ALLIS PRIMARY CARE PHYSICIANS, S.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for West Allis Primary Care Physicians. S.C. to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. West Allis Primary Care Physicians, S.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to West Allis Primary Care Physicians, S.C. at 12555 W. National Avenue, Suite 201, New Berlin, WI 53151.

With this consent, West Allis Primary Care Physicians, S.C. may call my home or other alternative location and leave a message on voice mail, or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, West Allis Primary Care Physicians, S.C. may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to West Allis Primary Care Physicians, S.C.'s use and disclosure of my personal health information to carry out treatment, payment and healthcare operations, and I have received and reviewed the Privacy Policy Notice of West Allis Primary Care Physicians, S.C.

If I do not sign this consent, or later revoke it, West Allis Primary Care Physicians, S.C. may decline to provide treatment.

_____	_____
Print Name of Patient	Print Name of Legal Guardian
_____	_____
Signature of Patient or Legal Guardian	Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names _____ Birth Date/Medical Record Number _____

Street Address _____ City, State, Zip Code _____

AUTHORIZES

Previous Physician _____

Telephone # _____ Fax # _____

Street Address _____

RELEASE OF PROECTED HEALTH INFORMATION TO:
West Allis Primary Care Physicians, S.C.
12555 W. National Avenue, Suite 201
New Berlin, WI 53151-4061
Phone: 262-754-8005 Fax: 262-754-8003

City, State, Zip Code _____

INFORMATION TO BE RELEASED

☐ Info Necessary for Continued Care ☐ Discharge Summary ☐ History & Physical
☐ Operative/Procedural Report ☐ Pathology Report ☐ Consultations
☐ Labs ☐ X-rays ☐ EKG/EMG/EEG
☐ PT/SP/OT ☐ ER/UC ☐ Progress Notes
☐ Immunization ☐ Other _____

(Contact Medical Imaging Department to obtain films) In compliance with Wisconsin and Minnesota Statutes which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Alcohol Abuse or Test Results ☐ Developmental Disabilities ☐ Drug Abuse or Test Results
☐ HIV Test Results, AIDS, or AIDS-Related Disease ☐ Mental Health
☐ Sexually Transmitted Disease ☐ Other _____

THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):

☐ Further Medical Care ☐ Work Comp ☐ Relocation/Moving
☐ Attorney/Court Case ☐ Insurance Change ☐ Insurance
☐ At the request of the individual ☐ Other comments _____
☐ Changing Physicians (explain): _____

REDISCLOSURE NOTICE: I understand the information used or disclosed on this authorization may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy Standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION
Right to Inspect or Copy the Health Information to Be Used or Disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Health Information Service Dept. Right to Receive Copy of This Authorization- I understand that if I agree to sign this authorization, I will be provided with a copy of it. Right to Refuse to Sign This Authorization- I understand I am under no obligation to sign this form and the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services). Right to Revoke This Authorization- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Health Information Service Dept. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____ DATE: _____
(If signed by other than patient, state relationship and authority to do so).

☐ Parent ☐ Guardian ☐ POA for Healthcare ☐ Spouse/Adult Family Member of Deceased Patient

WEST ALLIS PRIMARY CARE PHYSICIANS, S.C.

OFFICE POLICIES

Welcome to West Allis Primary Care Physicians, S.C. clinic. Thank you for choosing us for your healthcare needs. To have a smooth and pleasant navigation of the health system, we want you to be aware of our clinic policies and procedures. We are **not gatekeepers**. We are **your advocate**.

We strive to serve you promptly and on time. Please arrive 5-10 minutes prior to appointment in order for the medical assistants to update your records and review medications. To efficiently handle your concerns, bring a list of medications, prescription renewals needed and the issues you want addressed at the time of the visit. Upon arrival, check in at the front desk, so we may give you the appropriate attention.

Medical records are requested before the first appointment to ensure optimal transition of care. Make sure that your previous physician's office has complied with the request. Our doctors will review those records at the time of visit.

Copay must be paid at the time of appointment. If you cannot make your required copay, we have the option to reschedule your appointment. We accept cash or checks only.

To avoid disruption of supply of long-term medications, call your pharmacy for refills two weeks before you run out of medications. It is the pharmacy's obligation to notify the doctor's office of prescription renewal requests. Refills are not considered emergencies and are taken care of during regular business hours. Refills will be denied unless seen within the past 12 months for those with chronic medical issues.

Medications that require prior authorization take about a week to get processed by the insurance company after the request has been received. It is your responsibility to contact your insurance carrier with questions regarding what medications they cover. Bring a copy of preferred medications from your insurance company on the day of your appointment. To ensure your safety, an **appointment is necessary** when requesting to change medications due to cost or formulary change.

A live person answers all phone calls received at the office during clinic hours. We do not use automated machines. To minimize phone traffic, it is appreciated if all issues can be addressed in one phone call.

The doctors may order blood and other ancillary test prior to appointment. If you fail to have them done, notify our office to reschedule your appointment. Our doctors aim to discuss test results, give recommendations for treatment and address your questions and concerns during appointments to maximize satisfactory outcome. From time to time, you may request a copy of your tests. We do not have unlimited resources to keep reproducing those records, so make a file for yourself, as you may need them for your other appointments.

Our doctors cross cover for each other for admissions and weekend calls. They take turns with hospital admissions. The admitting physician takes care of that patient until he/she is discharged, who then follows up with his/her primary doctor for **continuity of care**. They work under a **common philosophy** and continue to update on their clinical skills. Our doctors are accessible to their patients everyday as a free service to our patients. We ask that calls be limited to urgent matters as a courtesy for your doctor's time.

NO SHOW/CANCELLATION POLICY

In an effort to decrease unnecessary expenditures and to contain our fees, we have implemented a **No Show/Cancellation Policy** for all our patients. Please be advised that you are allowed **one no show or same day cancellation** appointment at which we will gladly reschedule without any charges. On your **second no show or same day cancellation**, you will be charged a **$25.00 fee** that must be paid prior to making any new appointments. On your **third no show or same day cancellation**, you will be charged a **$25.00** fee and we reserve the **right to terminate** the patient-doctor relationship at this office.

We understand that everyone might have an unforeseen event in which you cannot make your appointment with us. We only ask that you have the courtesy to call us at least **24 hours in advance** to reschedule your appointment. We allotted the one grace appointment in which you are not charged a fee for that sudden emergency. For the subsequent missed appointments, we are charging a nominal fee to cover for the staff that is at hand to provide your needs. Please be assured that we want to run this office as efficiently as possible in order to provide you the best care; and that this policy is in place to help us achieve that goal. We appreciate your understanding and cooperation in this matter.

Name: _____ Signature: _____ Date: _____

Witness: _____

PATIENT DATA BASE

(PLEASE PRINT)

NAME: _____ DATE: _____

REASON FOR VISIT: _____

HOW DID YOU HEAR ABOUT US? _____

DOCTORS YOU ARE CURRENTLY SEEING: _____

PAST MEDICAL HISTORY *(Check box and indicated the date of diagnosis)*

Heart							
	☐	High Blood Pressure	_____		☐	Heart Block	_____
	☐	Congestive Heart Failure	_____		☐	Heart Attack	_____
	☐	Heart Murmur/Valve Dse	_____		☐	Irregular Rhythm	_____
	☐	Peripheral Vascular Dse	_____		☐	Varicosities	_____
Lungs							
	☐	Pulmonary Fibrosis	_____		☐	Frequent Bronchitis	_____
	☐	Pneumonia	_____		☐	COPD	_____
Gi							
	☐	GERD	_____		☐	Hernia	_____
	☐	Gastritis/Ulcers	_____		☐	Constipation	_____
	☐	Irritable Bowel Syndrome	_____		☐	Colitis	_____
	☐	Diverticulitis	_____		☐	Pancreatitis	_____
	☐	Polyps	_____		☐	Hemorrhoids	_____
	☐	Hepatitis	_____		☐	Gallbladder Stones	_____
Gu							
	☐	Bladder Incontinence	_____		☐	Infertility	_____
	☐	Kidney Stones	_____		☐	Venereal Dse/STD	_____
Male							
	☐	Prostate Enlargement	_____		☐	Impotence/ E.D.	_____
Female							
	☐	Cystic Breast	_____		☐	Ovarian Cyst	_____
	☐	Endometriosis	_____		☐	Uterine Fibroids	_____
	☐	Sexual Problems	_____				
Glands							
	☐	Thyroid Disorder	_____		☐	High Cholesterol	_____
	☐	Diabetes	_____		☐	Osteoporosis	_____
		(Frequency blood sugar checked)	_____				
Skin							
	☐	Rash or Eczema	_____		☐	Warts	_____
	☐	Skin Cancer	_____		☐	Chickenpox	_____
	☐	Psoriasis	_____		☐	Shingles	_____
Ent							
	☐	Hearing Loss	_____		☐	Sinus Problem	_____
Eye							
	☐	Macular Degeneration	_____		☐	Glaucoma	_____
	☐	Cataract	_____		☐	Retinopathy	_____
Neurologic							
	☐	Migraine	_____		☐	Dementia	_____
	☐	Parkinson's	_____		☐	Seizures	_____
	☐	Stroke	_____				

PAST MEDICAL HISTORY *(continued from previous page)*

Musculoskeletal							
	☐	Osteoarthritis	_____		☐	Temporal Arteritis	_____
	☐	Rheumatoid Arthritis	_____		☐	Fibromyalgia	_____
	☐	Herniated Disc	_____		☐	Systemic Lupus	_____
	☐	Tendinitis	_____		☐	Foot Problems	_____
	☐	Gout	_____		☐	Carpal Tunnel	_____
Heme/Oncology							
	☐	Anemia	_____		☐	Blood Clots	_____
	☐	Cancer	_____				
Allergy							
	☐	Asthma	_____		☐	Allergic Rhinitis	_____
Psych							
	☐	Bipolar	_____		☐	Depression	_____
	☐	Obsessive-Compulsive Dis.	_____		☐	Anxiety/Panic	_____
Any other conditions not mentioned above:							
_____							
_____							
_____							

PAST SURGICAL HISTORY *(Check box and please indicate date of surgery)*

Head and Neck							
	☐	Brain	_____		☐	Cataract	_____
	☐	Lasik	_____		☐	Sinus	_____
	☐	Tonsils	_____		☐	Adenoids	_____
	☐	Thyroid	_____				
Heart and Circulation *(Please include dates and which hospital if known)*							
	☐	Carotid	_____		☐	Angioplasty	_____
		(hospital)	_____			*(hospital)*	_____
	☐	Heart Bypass	_____		☐	Defibrillator	_____
		(hospital)	_____			*(hospital)*	_____
	☐	Pacemaker	_____				
		(hospital)	_____				
Pulmonary/Allergy							
	☐	Lung L/R	_____		☐	Biopsy	_____
	☐	Bronchoscopy	_____				
Gastrointestinal							
	☐	Appendix	_____		☐	Gallbladder	_____
	☐	Hemorrhoid Surgery	_____		☐	Hernia Repair	_____
Genito-urinary							
	☐	Bladder	_____		☐	Kidney Stones	_____
	☐	Prostate	_____		☐	Vasectomy	_____
Musculoskeletal							
	☐	Carpal Tunnel Repair	_____		☐	Foot	_____
	☐	Joint/s	_____		☐	Spine	_____
		(Specify)	_____				
Skin							
	☐	Cyst Removal	_____		☐	Biopsy	_____
		(Which body part)	_____				
Other surgical procedures not asked above:							
_____							
_____							
_____							

OB/GYN HISTORY (For females)

Age of first menstruation	_____		Age of last menstruation	_____	
Number of pregnancies	_____		Number of childbirth	_____	
Number of abortions	_____				
Birth control pills	☐ Yes	☐ No	Length of use	_____	
Menopause	☐ Yes	☐ No	Date of menopause	_____	
Estrogen after menopause	☐ Yes	☐ No	Length of use	_____	
☐ Breast Biopsy R/L _____	_____		☐ Mastectomy R/L _____	_____	
☐ Hysterectomy	_____				
Other surgical procedures not asked above:					
_____					
_____					

FAMILY HISTORY

Father:	Age: _____	☐ Living	☐ Deceased	Medical conditions:	_____
Mother:	Age: _____	☐ Living	☐ Deceased	Medical conditions:	_____
Brothers:	_____	☐ Living	☐ Deceased	Medical conditions:	_____
Sisters:	_____	☐ Living	☐ Deceased	Medical conditions:	_____
Son/s:	_____	Health Status:	_____		
Daughter/s:	_____	Health Status:	_____		
Paternal:	Grandmother:	Health Status:	_____		
	Grandfather:	Health Status:	_____		
Maternal:	Grandmother:	Health Status:	_____		
	Grandfather:	Health Status:	_____		

PERSONAL AND SOCIAL HISTORY

Marital Status:	☐ Single	☐ Married	☐ Widowed	☐ Separated	☐ Divorced
Level of Education:	_____	Occupation:	_____		
Religious Affiliation:	_____				
Pets:	☐ Yes	☐ No	Military Service:	☐ Yes	☐ No

ADVANCE DIRECTIVES:

Do you have a living will	☐ Yes	☐ No	Do you have a Power of Attorney for health care	☐ Yes	☐ No
Designated to:	Name: _____		Phone: _____		

HABITS

Smoking:	☐ Never	☐ _____ cigarettes per day, since _____		☐ Quit in _____	
Alcohol:	☐ Yes ☐ No	☐ Daily	☐ Weekly	☐ Occasionally	
	How much consumed in one week _____		☐ Beer ☐ Wine	☐ Hard Liquor	
Caffeine:	_____ cups/day _____		Soda: _____ cups/day	What kind? _____	
Street drug:	☐ Yes ☐ No	Type: _____			
Exercise:	☐ Yes ☐ No	Type: _____	Duration: _____		
Sleeping problems:	☐ Falling asleep	☐ Staying asleep	☐ Snoring	☐ No problems	
Seatbelt:	☐ Always	☐ Most of the time	☐ Never		
Occupational Exposure:	☐ Bodily Fluids	☐ Fumes	☐ Chemicals		
Method of Contraception:	_____				

IMMUNIZATION HISTORY

Hepatitis A Vaccine	Date:	_____		Td/Tdap	Date:	_____
Hepatitis B series	Date:	_____		MMR	Date:	_____
Gardasil/HPV Vaccine (for females)	Date:	_____		Flu Shot	Date:	_____
Pneumovax	Date:	_____		Zostavax/Shingles Vaccine	Date:	_____

HEALTH PROMOTION

Last Physical Exam	Date:	_____		
Pap/Pelvic	Date:	_____	By whom:	_____
Mammogram	Date:	_____	Where:	_____
PSA	Date:	_____		
Bone Density/DXA Scans	Date:	_____		
Colonoscopy	Date:	_____		

PROCEDURES

Allergy Testing	Date:	_____	Type:	_____
Barium Enema	Date:	_____	Type:	_____
Cardiac Catheterization	Date:	_____	Type:	_____
CT Scan	Date:	_____	Type:	_____
Cystoscopy	Date:	_____	Type:	_____
Echocardiogram	Date:	_____	Type:	_____
EMG/Nerve Conduction	Date:	_____	Type:	_____
Upper GI Endoscopy	Date:	_____	Type:	_____
EEG	Date:	_____	Type:	_____
Hearing Test	Date:	_____	Type:	_____
IVP	Date:	_____	Type:	_____
MRI	Date:	_____	Type:	_____
Pulmonary Function	Date:	_____	Type:	_____
Stress Test	Date:	_____	Type:	_____
Ultrasound	Date:	_____	Type:	_____
X-ray	Date:	_____	Type:	_____
Other tests not mentioned above:				
_____				
_____				

IF 65 YEARS OR OLDER *(Please check the correct boxes)*

Living Arrangements:	☐ Home	☐ Senior Housing	☐ Assisted Living	☐ Group Home	☐ Nursing Home
Assistive Devices	☐ None	☐ Cane	☐ Walker	☐ Wheelchair	

Activities of Daily Living – Independent with:

☐ Bathing	☐ Dressing	☐ Grooming	☐ Eating
☐ Ambulating	☐ Transfers	☐ Hygiene	☐ Continence

Instrumental Activities of Daily Living – Independent with:

☐ Telephone Use	☐ Traveling	☐ Shopping	☐ Meal Preparation
☐ Housework	☐ Taking Medication	☐ Managing Finances	

Ability to Drive ☐ Yes ☐ No

Other concerns you wish to discuss with your doctor:

_____

_____

PRESCRIPTION MEDICATIONS

Currently taking (including inhalers)

Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______

Pharmacy Phone Number (if known): ______________________________

OVER THE COUNTER PRODUCTS AND HERBAL MEDICINES

Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______
Name:	______	Dosage:	______	Frequency:	______

DRUG ALLERGY or REACTION TO MEDICATIONS

Name:	______	Reaction:	______
Name:	______	Reaction:	______
Name:	______	Reaction:	______
Name:	______	Reaction:	______
Name:	______	Reaction:	______
Name:	______	Reaction:	______
Name:	______	Reaction:	______

Latex Allergy:	☐ Yes	☐ No		
Food Allergy:	☐ Yes	☐ No	Type:	______

I certify the above information to be true and correct to the best of my knowledge.

______________________________ ______________

Signature Date

Thank you for choosing West Allis Primary Care Physicians!