DURANT FAMILY MEDICINE CLINIC HEALTH QUESTIONNAIRE NEW PATIENT

Name: Date: Birthday: Chart #

Reason For Visit

HAVE YOU BEEN OUT OF THE UNITED STATES ___**No** ____ **Yes-Date**__________**Where**________________________

Medical History ***Mark "C" for current problems, check and indicate date when you had any of the following symptoms or diseases.***

	ADHD	Alcohol drinks per week
	ALLERGIC RHINITIS	Tobacco cig/day #years
	ANEMIA	year quit
	ANXIETY	Second Hand Smoke Exposure No Yes
	ARTHRITIS	Caffeine (Coffee /Tea/Soda) Cups per day
	ASTHMA	Illicit Drugs No Yes - Please list
	BACK PAIN CHRONIC LOW	**MEDICAL MARIJUANA CARD _____NO _____YES**
	BOWEL CHANGES/CONSTIPATION/DIARRHEA	Do you exercise regularly ____No ____Yes
	CANCER - what kind?	Sexually Active No Yes
	COPD	**FEMALES - PLEASE COMPLETE THE FOLLOWING:**
	DEPRESSION	Pain / Bleeding during or after sex No Yes
	DIABETES	Menstrual Flow:
	DIVERTICULOSIS	Regular Irregular Painful Cramps
	GERD	Days of Flow Length of Cycle
	HEART PROBLEMS:]	Date - 1st day last period
	HEPATITIS	Number of: Pregnancies Live Births
	HIGH BLOOD PRESSURE	Miscarriages Abortions
	HIGH CHOLESTEROL	Birth Control method
	HYPOTHYROIDISM	Birth Control pill name
	OBESITY	Hot Flashes NO YES
	SEIZURE	Date of last PAP test
	DIFFICULTY WITH URINATION	Normal Abnormal
	COVID-19 **DATE:**	Date of last Mammogram
	OTHER:	Normal Abnormal

Hospital Admissions	Year	HOSPITALIZATION	Year	SURGERY
Not Including Pregnancies				

Family History

FATHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other______________________

Father - Year of Birth________________ [ ] Alive [ ] Deceased

MOTHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other______________________

Mother - Year of Birth ________________ [ ] Alive [ ] Deceased

SIGN HERE ->

RESPONSIBLE PARTY/GUARDIAN SIGNATURE **DOCTOR SIGNATURE**

Name: **Date:** **Date of Birth:**

Medications prescribed by Doctors	Strength	How Often Do You Take This Medication
MEDICINE YOU TAKE NOT PRESCRIBED BY A DOCTOR	**STRENGTH**	**HOW OFTEN DO YOU TAKE THIS MEDICATION**
If you have a Medical Marijuana Card please describe how you use the marijuana (smoke, eat gummies, and how much you use each day)		
LIST ALL YOUR ALLERGIES		
COVID VACCINE YES NO	**DATE OF LAST VACCINE:**	

Patient_______________________________________

Alcohol Use Screening Audit C

Did you have a drink containing alcohol in the past year?

____Yes
____ No

If Yes: How often did you have a drink containing alcohol in the past year?

_____ Never
_____ Monthly or less
_____ Two to four times in a month
_____Two to three times per week
_____Four or more times a week

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

_____ 1 or 2 _____ 3 or 4 _____ 5 or 6 _____7-9 _____10 or more

If Yes: How often did you have six or more drinks on one occasion in the past year?

_____Never _____Less than monthly _____Monthly _____Weekly _____Daily

Depression Screening PHQ2

Please indicate the answer that best describes you during the past two weeks:

Do you have little interest or pleasure in doing things?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Feeling down, depressed or hopeless?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Tobacco Control

___Non Smoker

___Chews Tobacco

___Former Smoker YOU MAY STOP HERE IF YOU DO NOT CURRENTLY SMOKE.

___Current Smoker ___everyday ___some days, but not every day

___5 or less ___6-10 ___11-20 ___21-30 ___31 or more

After you wake up when do you smoke your first cigarette ___5 min ___6-30min ___31-60min ___after 60

Are you interested in quitting? ___Ready to quit ___Thinking about quitting ___Not ready to quit

Sexual History

Have you had sex in the last 12 months? (vaginal, oral or anal)? _____Yes _____No

With _____Men Only _____Women Only _____With Both Men & Women

Do you use protection? _____Yes _____No

Type of Birth Control: ____

Have you ever had an STD or STI? _____Yes _____No

Chlamydia? _____Yes _____No

Gonorrhea? _____Yes _____No

Syphilis? _____Yes _____No

Herpes? _____Yes _____No

Other? _____Yes _____No

DURANT FAMILY MEDICINE CLINIC NEW PATIENT FORMS

1400 BRYAN DR SUITE 201 DURANT OK 74701 PHONE 580.924.5500 FAX 580.924.1991

DATE_____/_____/_____

PATIENT NAME____

LAST **FIRST** **MIDDLE** **(MAIDEN NAME IF MARRIED FEMALE)**

Address____City______________________State____________Zip___________

Home Phone(_____) _________-____________Cell Phone(_____) _________-___________Work Phone(_____) ________-__________

DATE OF BIRTH_____/_____/_____ MALE FEMALE Single Married Divorced Widowed Separated

SSN______-______-_________ **[ ]** Retired **[ ]** Disabled Occupation______________________________

Employer____ Full Time Part Time Temporary

Employer Address_____________________________________City__________________State_______________Zip__________

YOUR PERSONAL EMAIL (or parent/guardian):

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PLEASE CIRCLE ANSWERS FOR THE FOLLOWING INFORMATION: **Language**: English Espanol Other______________________________

Race: White Hispanic American Indian Asian Black Other:____

Ethnicity: Choctaw Cherokee Hispanic Non-Hispanic Other:____

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If patient is a minor, under 18 or student under 21, please provide the following Parental/Legal Guardian Information

Responsible Party/Legal Guardian____SSN______-______-_________

LAST FIRST MIDDLE

Date of Birth_____/_____/_____Address ☐Same or _________________________________City_________State___Zip_______

Relationship to Patient ☐Father ☐Mother ☐Legal Guardian ☐Other-describe_______________________________

Home Phone(_____) _______-__________Cell Phone(_____) _______-___________Work Phone(_____) _______-__________

Employer____Occupation_________________________

Employer Address______________________________________City____________________State_______________Zip______

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INSURANCE INFO – COMPLETE ONLY IF PATIENT IS NOT THE INSURED or IF MINOR IS COVERED BY PARENTS INSURANCE

Insurance Company____ **☐Spouse ☐Parent ☐Other**

Relationship to Patient

Name of Insured____ ____/_____/_____ _______-________-_______

LAST FIRST Date of Birth Social Security Number

Does the Patient live with the Insured? **[ ]** Yes **[ ]** No **- If NO complete the following as it relates to the INSURED**

Home Phone(_____) _________-__________Cell Phone(_____) _________-_________Work Phone(_____) ________-_______

Address of Insured ____

Address/P O Box City State ZIP

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P**REFERRED PHARMACY – Please Circle One:** Corner Drug Medical Center Pharmacy

Medicine Store Pruett's Walgreens Wal-Mart-Durant

WalMart-Madill OTHER:____Fax-__________________________

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Patient Name________________________________DOB_____/______/_____MR#_________________

DFMC uses **automated TEXTS** for appointments, lab results and general notifications like flu shot reminders, etc.

PLEASE PROVIDE YOUR **CELL PHONE** NUMBER____

[ ] I DO NOT HAVE A CELL PHONE   I prefer a phone call reminder to phone number _____________________

We are reducing the phone calls for appointment reminders. If you do not have a cell phone to receive text, you may not receive reminders in the future. Please remember to check for unknown number messages and enter our phone number in your contacts. Please discuss any special circumstances with the receptionist.

Preferred Method of Contact

How should the staff or doctor contact you:

Contact me at **[ ]** Home Phone **[ ]** Cell Phone **[ ]** Work Phone [ ] Patient Portal

DFMC may **[ ]** leave a detailed message **[ ]** leave a call back number only

Other info____

I authorize the following person(s) to obtain or provide information regarding my appointments, emergency contact, health and financial/insurance information: Please provide at least 2 contacts.

____Relationship_________Phone_________________

____Relationship_________Phone_________________

____Relationship_________Phone_________________

DFMC is unable to provide any information to anyone not listed above due to HIPAA Privacy Laws.

I have an Advance Directive regarding healthcare issues **[ ]** No **[ ]** Yes – Please provide a copy to DFMC

I have reviewed Durant Family Medicine Clinic's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document which is posted to the right of the check-in window. The information contained on this demographics form is true and correct. If this information changes I acknowledge it is my responsibility to update this information with Durant Family Medicine Clinic.

____   ________/_________/_________

Signature of Patient /Legal Guardian if Patient is a Minor   Date