THE BROADWAY CLINIC - PATIENT INFORMATION

TODAY'S DATE:________________________ Your Social Security Number # ☐☐☐ ☐☐ ☐☐☐☐

FIRST NAME:______________________ LAST NAME:______________________________________ MI:______ HEIGHT:_______ WEIGHT:______

HOME ADDRESS:____CITY:_______________________________ STATE:_______ ZIP_____________

HOME PHONE: (   ) _______________________CELL PHONE: (   )_____________________ DATE OF BIRTH:__________AGE _______

WHO REFERRED YOU?
UNION WEBSITE FACEBOOK FRIEND/FAMILY/COWORKER OTHER

E-MAIL:____SEX: MALE FEMALE

EMERGENCY CONTACT: NAME ____________________________ PHONE (   )_________________RELATIONSHIP_____________________

CURRENT EMPLOYMENT INFORMATION ☐ **Check here if unemployed**

EMPLOYER:____

ADDRESS:____________________________CITY:______________

STATE:______ZIP:_________OCCUPATION:______________________

EMPLOYER PHONE: (   )_______________

HEALTH INSURANCE INFORMATION -

Insurance Carrier/Network:____

Name of Insured:__________________________ Relationship: ___________

Insured's Employer:_______________________ GROUP NO./ID:__________

Insured's SSN# _______ - _____ - ________ Insured's DOB: ___/____/____

YOUR MEDICAL HISTORY

When was you last menstrual period? ________________ (mm/dd/yy) **Is there any possibility that you are pregnant?** **YES** **NO**

Are you allergic to any medications? **YES** **NO** **If yes, please list** ____

Are you currently taking any medications? **YES** **NO** **If yes, please list**____

SURGICAL HISTORY Please list any surgeries that you have had. Include year.

FAMILY MEDICAL HISTORY

SOCIAL HISTORY

Do you have a family history of…		RELATIONSHIP TO YOU, COMMENTS, OR NOTES
Diabetes		
Stroke or Heart Attack		
Arthritis		
Cancer		
Anesthesia Problems		
Epilepsy		
Gout		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Other (please list)		

Marital Status: (circle one)	SINGLE MARRIED WIDOWED		
Current Occupation: (If retired, previous)			
Have you ever smoked? YES NO	QUIT—When?_____________		
If yes to smoking- How much?	Number of Years		
Do you drink alcohol?	YES	NO	
If YES to alcohol,- # of Drinks	Occasionally Socially Daily Weekly		