IOWA PARK
CLINIC

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Sex: ☐M ☐F Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Marital Status: ☐M ☐S ☐D ☐W

Race: ☐Caucasian ☐ African American ☐Latino/Hispanic ☐Asian ☐Native American ☐Other

Ethnicity: ☐Hispanic ☐ Non-Hispanic ☐Unknow Preferred Language: _____

EMERGENCY CONTACT

Emergency Contact: _____

Phone: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Provider: _____

Policy Holder Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to patient: _____

Policy #: _____ Group #: _____

Secondary Insurance Provider: _____

Policy Holder Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to patient: _____

Policy #: _____ Group #: _____

EMPLOYMENT

Status: ☐ Employed ☐ Retired ☐ Unemployed

Occupation: _____ Employer: _____

IOWA PARK CLINIC

MEDICAL HISTORY

Do you have any of these medical problems? If **YES,** please circle.

Eyes:	cataracts, glaucoma, glasses/contacts, macular degeneration, other:
Ears, Nose & Throat:	allergies, sinusitis, dental abscess, swollen glands, chronic sore throat, TMJ
Heart:	high blood pressure, irregular heartbeat, heart failure, heart attack, CAD
Lungs:	asthma, emphysema, COPD, pneumonia, sleep apnea, cancer
Stomach & Intestines:	reflux, ulcers, irritable bowel, diverticulosis, constipation, cancer
Urinary:	urine incontinence, prostate disease, STD, kidney stones
Muscles & Joints:	arthritis, pain in arms/legs/neck/back, radiating pain
Brain & Nerves:	seizures, headache, migraines, stroke, Parkinsonism, dementia
Skin:	acne, eczema, psoriasis, hives, cancer, other:
Hormones:	diabetes, thyroid, high cholesterol, menopausal, osteoporosis, gout
Blood:	anemia, bleeding, blood clots, cancer
Psychiatric:	depression, anxiety, bipolar, schizophrenia, other:

SURGERIES

SURGERY (specify left/right)	**MONTH/YEAR**

MEDICATIONS

MEDICATIONS (list all)	**DOSE**	**TIMES PER DAY**

Preferred Pharmacy: _____

IOWA PARK CLINIC

ALLERGIES ☐No Allergies

ALLERGY	ALLERGIC REACTION

FAMILY MEDICAL HISTORY

✓ Check all that apply	Alcohol/Drug Abuse	Asthma	Cancer	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Other:	Other:	Other:
Mother																	
Father																	
Brother																	
Sister																	
Maternal Grandmother																	
Maternal Grandfather																	
Paternal Grandmother																	
Paternal Grandfather																	

SOCIAL HISTORY

Smoker: ☐Current every day smoker ☐Former smoker ☐Never smoker

Smokeless Tobacco: ☐Current user ☐Former user ☐Never used

Do you drink alcohol? ☐Y ☐N # of Drinks/week:_____ Do you use recreational drugs? ☐Y ☐N

If you need more room on any section, please write on a blank sheet of paper and attach.