LECOM HEALTH
MEDICAL ASSOCIATES OF ERIE

First Name: ______________________________ Middle Initial: __________

Last Name: ______________________________ Date of Birth: ____/___/______

Social Security Number: ________-______-_________

Home Phone: ____________________

☐ OK to Leave Voicemail

Cell Phone: ____________________

☐ OK to Leave Voicemail

Native/ Preferred Language: ____________________________

Communication Needs: ☐ Hearing ☐ Vision ☐ Cognitive

Gender:
☐ Male
☐ Female
☐ Undifferentiated

Gender Identity:
☐Identifies as Male ☐Identifies as Female
☐Transgender Male ☐ Transgender Female
☐Neither exclusively Male or Female
☐Other ☐ Declined

Sexual Orientation:
☐Straight, Heterosexual ☐ Bisexual
☐Lesbian, Gay, Homosexual
☐Don't Know ☐ Declined ☐ Other

Address: ______________________________ City: ____________ State: ______ Zip: _________

Marital Status: ______________________ Employment/Student Status: ____________________

Employer/School: ________________ Occupation: ______________Work Number: ____________

Pharmacy Preference: ____________________________ Referring Doctor: ____________________

Family Doctor: ____________________ Phone Number: _______________ Last Seen: __________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Race: ☐ African American ☐ American Indian/Alaska ☐ Asian ☐ Caucasian ☐ Hispanic or Latino
☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Email: ____ ☐ Decline Email ☐ Decline Texts

** By providing your cell phone number and/or e-mail address, you allow Medical Associates of Erie to send personal information to you via e-mail/text/voicemail. This also includes e-mail/text/voicemails for appointment confirmation. If you prefer that we do not contact via text or email, please mark decline. Standard data messaging rates will apply for text confirmations**

Emergency Contact: __________________ Relationship: __________ Phone Number: __________

Primary Caregiver: __________________ Relationship: __________ Phone Number: ____________

Legal Guardian: ____________________ Relationship: __________ Phone Number: ____________

The following have been completed (please provide a copy of any documents for your medical record)**:**
☐ Advanced Directive for Health Care ☐ Living Will ☐ Physician Orders for Life Sustaining Treatment

Health Care Proxy: ____
Phone Number: ___________________________________ Relationship:____________________

Patient Name: ______________________________ Date of Birth: ______________

Account Information: Is the above referenced patient over the age of 18? ☐ Yes ☐ No
If yes, the patient is legally responsible for all financial obligations to this office.
If No, who is financially responsible for this account? ____________________ Relationship: ____________
Address: ______________________________ City: _______________ State: ___________ Zip: __________
Home Phone: _________________ Cell Phone: _________________ Date of Birth: ______/______/________
Social Security Number: ________-______-__________ Employer: ________________________________

Insurance information: Please provide your insurance card(s) to the receptionist. This will be scanned into our system to enable us to submit claims to your insurance company on your behalf.
If the patient is not the policy holder for their primary, or secondary insurance please list the subscriber's information below:

Primary Insurance Company: ______________________________ Effective Date: ____________

SUBSCRIBER Information for this Policy

Last Name: ______________________________ Home Number: ______________
First Name: ____________________ MI: ______ Cell Number: ______________
Address: ______________________________ City: ______________ State: ______ Zip: ________

Date of Birth: _________________ Gender: ☐ Male ☐ Female

Relationship to Patient:

ID or Policy #: ______________________________ ☐ Self ☐ Spouse
Group #: ______________________________ ☐ Child ☐ Other
Name of Employer: ______________________________

Secondary Insurance Company: ______________________________ Effective Date: ____________

SUBSCRIBER Information for this Policy

Last Name: ______________________________ Home Number: ______________
First Name: ____________________ MI: ______ Cell Number: ______________
Address: ______________________________ City: ______________ State: ______ Zip: ________

Date of Birth: _________________ Gender: ☐ Male ☐ Female

Relationship to Patient:

ID or Policy #: ______________________________ ☐ Self ☐ Spouse
Group #: ______________________________ ☐ Child ☐ Other
Name of Employer: ______________________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS, AND REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS OR PARTICIPATES.

SIGNED: ______________________________ Date: ____________________

I UNDERSTAND THE PROVIDER'S CHARGES MAY EXCEED THE INSURANCE PAYMENTS, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT. SHOULD MY ACCOUNT EVER BECOME DELINQUENT AND ELIGBLE FOR COLLECTION, I UNDERSTAND AN APPROPRIATE COLLECTION FEE WILL BE ASSESSED.

SIGNED: ______________________________ Date: ____________________

 Patient Name: ____________________ Date of Birth: __________

Please describe/explain the reason for today's appointment: ____________________

____

REVIEW OF SYSTEMS: Please check all that apply.

Constitutional
- ☐ Chills
- ☐ Decline in Health
- ☐ Fatigue
- ☐ Fever
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Head
- ☐ Dizziness
- ☐ Fainting
- ☐ Head Injury
- ☐ Headaches
- ☐ Pain

Eyes
- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Discharge
- ☐ Double Vision
- ☐ Excessive Tearing
- ☐ Eyeglass/Contact Use
- ☐ Eye Pain
- ☐ Glaucoma
- ☐ Infections
- ☐ Pain with Light
- ☐ Recent Injury
- ☐ Redness
- ☐ Vision Loss
- ☐ Unusual Sensations

Nose
- ☐ Discharge
- ☐ Frequent Colds
- ☐ Infections
- ☐ Nasal Obstruction
- ☐ Nosebleeds
- ☐ Runny Nose
- ☐ Sinus Infections

Mouth
- ☐ Bleeding Gums
- ☐ Change in Dentition
- ☐ Hoarseness
- ☐ Postnasal Drip
- ☐ Tongue Burning
- ☐ Voice Changes

Ears
- ☐ Discharge
- ☐ Hearing Aid
- ☐ Hearing Impairment
- ☐ Infections
- ☐ Pain
- ☐ Ringing in Ears

Throat & Neck
- ☐ Enlarged Tonsils
- ☐ Frequent Sore Throats
- ☐ Lumps
- ☐ Tenderness

Respiratory
- ☐ Bringing up Sputum
- ☐ Cough
- ☐ Coughing Blood
- ☐ Pain with Breathing
- ☐ Wheezing
- ☐ Wheezing w/ Exertion

Cardiovascular
- ☐ Chest Pain
- ☐ Extremity(s) Cool
- ☐ Extremity(s) Discolored
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Short of Breath
- ☐ Short of Breath w/ Exertion
- ☐ Swelling of Legs or Feet
- ☐ Varicose Veins

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black Tarry Stools
- ☐ Change in Appetite
- ☐ Change in Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Rectal Pain
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Musculoskeletal
- ☐ Arthritis
- ☐ Back Problems
- ☐ Gout
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Muscle Cramps
- ☐ Muscle Stiffness
- ☐ Paralysis
- ☐ Restricted Motion
- ☐ Tremors
- ☐ Unsteady Gait

Psychiatric
- ☐ Behavioral Changes
- ☐ Depression
- ☐ Disorientation
- ☐ Disturbing Thoughts
- ☐ Excessive Stress
- ☐ Hallucinations
- ☐ Memory Loss
- ☐ Mood Changes
- ☐ Nervousness

Breasts
- ☐ Discharge
- ☐ Lumps
- ☐ Pain
- ☐ Tenderness

Skin
- ☐ Bruising
- ☐ Dryness
- ☐ Eczema
- ☐ Hair Texture Changes
- ☐ Hives
- ☐ Itching
- ☐ Loss of Hair
- ☐ Lumps
- ☐ Mole Increased Size
- ☐ Nail Growth Changes
- ☐ Nail Texture Changes
- ☐ Pitting Nails
- ☐ Rash
- ☐ Skin Color Change
- ☐ Ulcer or Wound

Neurological
- ☐ Blackouts
- ☐ Loss of Consciousness
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling or Burning

Endocrine
- ☐ Cold Intolerance
- ☐ Excessive Urination
- ☐ Goiter
- ☐ Heat Intolerance
- ☐ Hot Flashes
- ☐ Increased Thirst
- ☐ Sweats

Hematologic/Lymph
- ☐ Anemia
- ☐ Bleeds Easily
- ☐ Blood Clots
- ☐ Easy Bruisability
- ☐ Enlarged Lymph Nodes
- ☐ Low Blood Cell Counts

Allergic/Immunologic
- ☐ Itchy Eyes
- ☐ Seasonal Allergies
- ☐ Sneezing
- ☐ Watery Eyes

Urinary
- ☐ Awakening to Urinate
- ☐ Blood in Urine
- ☐ Burning or Pain w/ Urination
- ☐ Difficulty Starting Stream
- ☐ Flank Pain
- ☐ Frequency
- ☐ Incontinence
- ☐ Retention
- ☐ Urgency
- ☐ Urine Discoloration or Odor

Genitals ☐ Male ☐ Female
- ☐ Discharge
- ☐ Irregular Menstruation
- ☐ Itching
- ☐ Lesions
- ☐ Pain
- ☐ Sexual Problems
- ☐ Venereal Disease

Patient Name: ______________________ Date of Birth: __________

Allergies or Intolerance to Medications or Food (include type of reaction): ☐ **No Known Allergies**

MEDICATIONS: Please list (or attach a copy) all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs, inhalers, etc. ☐ **I am not currently taking any medications.**

Name of Medication	Dosage (e.g. mg/pill)	Times per Day

☐ **Medication List Attached** ☐ **Additional Medications Listed on Back of Form**

CONSENT FOR MEDICATION HISTORY REVIEW: I authorize Medical Associates of Erie to obtain an electronic record of my medication history to aid in the complete documentation within my medical record.

Patient Signature: ______________________

FAMILY HISTORY: Please note below any history of medical problems in the family. Please include details such as relationship of family member and if they are alive or deceased.

Were you adopted? ☐Yes ☐No ☐ **Family History Unknown**

 Patient Name: ______________________ Date of Birth: ____________

PAST MEDICAL HISTORY: Please list any past medical conditions with pertinent details including recent hospitalizations and/or ER visits.

____

____

____

____

____

____

____

____

SOCIAL HISTORY: Please check the appropriate option.

Do you Smoke? ☐ Yes ☐ No
Packs per Day: _____________
Number of Years: _________________

Have you ever smoked? ☐ Yes ☐ No
Do you use any other tobacco products? ☐ Yes ☐ No
Please Specify: ____________________________________

Do you Drink Alcohol? ☐ Yes ☐ No Type: ☐ Beer ☐ Wine ☐ Liquor Drinks per week: ______________

Do you Drink Caffeine? ☐ Yes ☐ No Drinks per week: ____________________

Do you Use Recreational Drugs? ☐ Yes ☐ No Please specify: __________________ Last used: ________

MISC SOCIAL HISTORY: Please check the appropriate option.

Military Service? ☐ Yes ☐ No Branch: _____________ When did you serve? _______________________

Location of Service: ____

Do you live alone? ☐ Yes ☐ No Members of your household: ____________________________________

Education: ☐ Some College ☐ Some High School ☐ High School Graduate ☐ GED
☐ Vocational School ☐ College Graduate ☐ Post Graduate Degree

Have you Recently lived or traveled to a foreign country? ☐ Yes ☐ No Where: ___________________________

Have you had any exposure to TB (tuberculosis)? ☐ Yes ☐ No When: ___________________________________

Have you had any environmental exposure such as asbestos, coal inhalation or second hand smoke? ☐ Yes ☐ No

Please Specify: ____

Do you have any pets? ☐ Yes ☐ No Please specify: ____

Do you have any known risk factors for HIV/AIDS? ☐ Yes ☐ No

Hobbies/ Interests
☐ Arts and Crafts ☐ Camping ☐ Cars ☐ Computers ☐ Dancing ☐ Fishing ☐ Gardening
☐ Hiking ☐ Hunting ☐ Motorcycle or Bike Riding ☐ Music ☐ Reading ☐ Spectator Sports
☐ Other: ____

 Patient Name: ______________________ Date of Birth: ____________

SURGICAL HISTORY: Please list any procedure or surgery that you have had and include any abnormal findings or complications.

☐ **No Surgical History**

____

____

____

____

____

____

____

OBSTETRIC HISTORY: For Women Only.

Total Pregnancies	Full Term	Premature	Abortions	Miscarriages	Ectopics	Multiple Births	Living

HEALTH MAINTENANCE: Please note any details regarding screenings or other physician visits you have had.

Test	Date	Office/Physician	Result
Bone Density (DEXA)			
Colonoscopy			
Dental Exam			
Eye Exam			
Flu Shot			
Hemoglobin A1C			
Hepatitis C Screening			
Hepatitis Vaccine			
Mammogram			
Pap Smear			
Prevnar 13			
Pneumovax 23			
Shingles Vaccine			
Tetanus Vaccine			
Other			
Other			

Name of Person Completing Form: ______________________

Relationship to Patient: ______________________