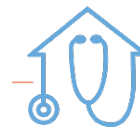

540 E. Main St.
Canfield, OH 44406
P: (330) 533-3351
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DATE:______/______/________

PATIENT DEMOGRAPHICS

NAME:____
FIRST MIDDLE LAST

DATE OF BIRTH:______/______/________ SOCIAL SECURITY #:________-________-__________ ☐ MALE ☐ FEMALE

STREET ADDRESS:____

CITY:______________________ STATE:______________________ ZIP CODE:______________

PRIMARY PHONE:______________________ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER

SECONDARY PHONE:______________________ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER

E-MAIL ADDRESS:____

PRIMARY INSURANCE:	SECONDARY INSURANCE (IF APPLICABLE):
______________________________	______________________________
SUBSCRIBER ID:____________________	SUBSCRIBER ID:____________________
GROUP ID: ______________	GROUP ID: ______________

NEXT OF KIN (FOR EMERGENCY):____

RELATION:______________________ PHONE:______________________________

LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

1.______________________________ 2.______________________________

3.______________________________ 4.______________________________

5.______________________________ 6.______________________________

LIST ANY PHYSICIANS AND/OR PRACTITIONERS YOU CURRENTLY SEE

NAME:______________________________ SPECIALTY:______________________

NAME:______________________________ SPECIALTY:______________________

NAME:______________________________ SPECIALTY:______________________

NAME:______________________________ SPECIALTY:______________________

NAME:______________________________ SPECIALTY:______________________

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

NAME	STRENGTH	DIRECTION	PRESCRIBED BY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

5. ______________________ 6. ______________________

RECORD THE LAST YEAR YOU HAD THE FOLLOWING. IF YOU DO NOT KNOW, LEAVE BLANK

COVID19 VACCINE YEAR:	BONE DENSITY SCAN YEAR:	COLONOSCOPY YEAR:
COVID19 BOOSTER (1) YEAR:	MAMMOGRAM YEAR:	PROSTATE EXAM YEAR:
COVID19 BOOSTER (2) YEAR:	ECHOCARDIOGRAM YEAR:	RECTAL EXAM YEAR:
PNEUMONIA VACCINE YEAR:	PAP SMEAR YEAR:	PELVIC EXAM YEAR:
SHINGLES VACCINE YEAR:	GLUCOSE READING YEAR:	HEARING EXAM YEAR:
HEPATITIS B SHOT YEAR:	HEMOCCULT TEST YEAR:	GLAUCOMA/EYE EXAM YEAR:
FLU VACCINE YEAR:	PSA TEST YEAR:	NUTRITIONAL THERAPY YEAR:
TETANUS DIPHTHERIA YEAR:	LIPID PANEL YEAR:	SMOKING CESSATION YEAR:
ABDOMINAL AORTIC ANEURYSM SCREENING YEAR:		
DIABETES SELF-MANAGEMENT TRAINING YEAR:		

LIST ANY PAST SURGERIES OR HOSPITALIZATIONS

1. ______ YEAR: ______ 2. ______ YEAR: ______

3. ______ YEAR: ______ 4. ______ YEAR: ______

5. ______ YEAR: ______ 6. ______ YEAR: ______

LIST ANY CHILDHOOD ILLNESSES

1. ______ 2. ______

3. ______ 4. ______

LIST HEALTH PROBLEMS AND CAUSES OF DEATH, IF APPLICABLE

			AGE	MEDICAL PROBLEMS
FATHER	☐ LIVING	☐ DECEASED		
MOTHER	☐ LIVING	☐ DECEASED		
BROTHER(S)	☐ LIVING	☐ DECEASED		
	☐ LIVING	☐ DECEASED		
	☐ LIVING	☐ DECEASED		
SISTER(S)	☐ LIVING	☐ DECEASED		
	☐ LIVING	☐ DECEASED		
	☐ LIVING	☐ DECEASED		
FATHER'S FATHER	☐ LIVING	☐ DECEASED		
FATHER'S MOTHER	☐ LIVING	☐ DECEASED		
MOTHER'S FATHER	☐ LIVING	☐ DECEASED		
MOTHER'S MOTHER	☐ LIVING	☐ DECEASED		

SOCIAL HISTORY

LIST EVERYONE IN YOUR HOUSEHOLD (INCLUDING PETS):			
1.		5.	
2.		6.	
3.		7.	
4.		8.	

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER:______

OCCUPATION:______ HOW LONG AT CURRENT EMPLOYER?:______

EDUCATION: ☐ HIGH SCHOOL ☐ COLLEGE ☐ SOME COLLEGE ☐ TRADE SCHOOL ☐ OTHER:______

DIET: ☐ BALANCED ☐ VEGETARIAN ☐ DIABETIC ☐ LOW SALT ☐ LOW FAT ☐ LOW CARB ☐ OTHER:______

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? ☐ YES ☐ NO IF YES, HOW MUCH?______

HAVE YOU EVER SMOKED OR CHEWED TOBACCO? ☐ YES ☐ NO IF YES, HOW MUCH?______

SOCIAL HISTORY (CONTINUED)

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH?________________________

ARE OTHERS CONCERNED ABOUT YOUR DRINKING? ☐ YES ☐ NO

PLEASE INDICATE IF YOU DO OR DO NOT NEED HELP PERFORMING THESE ROUTINE TASKS

Task	Response
FEEDING YOURSELF	☐ YES ☐ NO IF YES, WHO HELPS?________________________
GETTING FROM BED TO CHAIR	☐ YES ☐ NO IF YES, WHO HELPS?________________________
GETTING TO THE TOILET	☐ YES ☐ NO IF YES, WHO HELPS?________________________
GETTING DRESSED	☐ YES ☐ NO IF YES, WHO HELPS?________________________
BATHING OR SHOWERING	☐ YES ☐ NO IF YES, WHO HELPS?________________________
USING THE TELEPHONE	☐ YES ☐ NO IF YES, WHO HELPS?________________________
TAKING YOUR MEDICINES	☐ YES ☐ NO IF YES, WHO HELPS?________________________
PREPARING MEALS	☐ YES ☐ NO IF YES, WHO HELPS?________________________
SHOPPING FOR GROCERIES	☐ YES ☐ NO IF YES, WHO HELPS?________________________
DRIVING	☐ YES ☐ NO IF YES, WHO HELPS?________________________
CLIMBING A FLIGHT OF STAIRS	☐ YES ☐ NO IF YES, WHO HELPS?________________________
MANAGING MONEY (TRACKING EXPENSES/PAYING BILLS)	☐ YES ☐ NO IF YES, WHO HELPS?________________________
WALKING ACROSS THE ROOM (WITH A CANE/WALKER)	☐ YES ☐ NO IF YES, WHO HELPS?________________________
MODERATELY STRENUOUS HOUSEWORK (LAUNDRY)	☐ YES ☐ NO IF YES, WHO HELPS?________________________
SHOPPING FOR PERSONAL ITEMS (TOILETRIES/MEDICINES)	☐ YES ☐ NO IF YES, WHO HELPS?________________________

CHECK YES, NO, OR SOMETIMES FOR EACH QUESTION

Question	Response
DO YOU FIND IT DIFFICULT TO FOLLOW A CONVERSATION IN A CROWDED ROOM?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL THAT PEOPLE ARE MUMBLING OR NOT SPEAKING CLEARLY?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU EXPERIENCE DIFFICULTY FOLLOWING DIALOGUE IN A THEATER?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FIND YOURSELF ASKING PEOPLE TO SPEAK UP OR REPEAT THEMSELVES?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FIND MEN'S VOICES EASIER TO UNDERSTAND THAN WOMEN'S?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU EXPERIENCE DIFFICULTY UNDERSTANDING SOFT/WHISPERED SPEECH?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL HANDICAPPED BY A HEARING PROBLEM?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU EXPERIENCE RINGING/NOISES IN YOUR EARS?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU HEAR BETTER WITH ONE EAR THAN THE OTHER?	☐ YES ☐ NO ☐ SOMETIMES
HAVE ANY OF YOUR RELATIVES (BY BIRTH) HAD HEARING LOSS?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU HAVE DIFFICULTY UNDERSTANDING SPEECH ON THE TELEPHONE?	☐ YES ☐ NO ☐ SOMETIMES
DOES A HEARING PROBLEM CAUSE YOU TO FEEL EMBARASSED MEETING PEOPLE?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FIND IT DIFFICULT TO UNDERSTAND A SPEAKER AT A PUBLIC MEETING/EVENT?	☐ YES ☐ NO ☐ SOMETIMES
DOES A HEARING PROBLEM CAUSE YOU TO VISIT FRIENDS/FAMILY LESS OFTEN THAN YOU WOULD LIKE?	☐ YES ☐ NO ☐ SOMETIMES
HAVE YOU HAD ANY SIGNIFICANT NOISE EXPOSURE DURING WORK, RECREATION, OR MILITARY SERVICE?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL LITTLE INTEREST/PLEASURE IN DOING THINGS?	☐ YES ☐ NO ☐ SOMETIMES
DO YOU FEEL DOWN, DEPRESSED OR HOPELESS?	☐ YES ☐ NO ☐ SOMETIMES
ARE YOU AFRAID OF FALLING?	☐ YES ☐ NO ☐ SOMETIMES
HAVE YOU FALLEN IN THE PAST YEAR?	☐ YES ☐ NO ☐ SOMETIMES

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ☐ YES ☐ NO

____   ____/____/____

AUTHORIZED SIGNATURE   DATE

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PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE.

PATIENT'S NAME:____

DATE OF BIRTH:_______________________ **SOCIAL SECURITY NUMBER:**_________________________

TO GIVE CONSENT TO DISCLOSE HEALTH CARE INFORMATION TO SOMEONE OTHER THAN THE PATIENT, PLEASE WRITE THEIR NAME BELOW: (E.G. FAMILY MEMBER, CARETAKER)

NAME:____

I UNDERSTAND THAT MY HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT **Zinni Family Practice** WORKS VERY HARD TO PROTECT MY PRIVACY AND PRESERVE THE CONFIDENTIALITY OF MY PERSONAL HEALTH INFORMATION.

I UNDERSTAND THAT SIGNING THIS DOCUMENT MEANS THAT **Zinni Family Practice** MAY USE AND DISCLOSE MY PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTH CARE TO ME, TO HANDLE BILLING AND PAYMENT, AND TO TAKE CARE OF OTHER HEALTH CARE OPERATIONS. FAILURE TO SIGN THIS CONSENT MAY RESULT IN THE PHYSICIAN DECLINING TO TREAT ME.

UNDER THE TERMS OF THIS CONSENT, I CAN ASK **Zinni Family Practice** TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I UNDERSTAND THAT **Zinni Family Practice** DOES NOT HAVE TO AGREE TO MY REQUEST. IF HE DOES AGREE TO MY REQUEST, I UNDERSTAND THAT HE WOULD FOLLOW THE AGREED LIMITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO CANCEL THIS CONSENT IN WRITING AT ANY TIME. IF I DO CANCEL THE CONSENT, I UNDERSTAND THAT **Zinni Family Practice** MAY HAVE ALREADY USED OR DISCLOSED INFORMATION ABOUT ME AND CANCELING THIS CONSENT WOULD NOT AFFECT THE INFORMATION ALREADY USED OR DISCLOSED.

I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

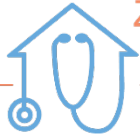
WRTING, SIGNING, AND DATING A LETTER TO **Zinni Family Practice** THAT SAYS I WANT TO REVOKE MY CONSENT TO AUTHORIZE THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS.

I UNDERSTAND IF I CANCEL THIS CONSENT, **Zinni Family Practice** IS NOT OBLIGATED TO PROVIDE FURTHER HEALTH CARE SERVICES TO ME.

MY SIGNATURE BELOW INDICATES THAT I AGREE TO THE POLICIES OUTLINED BY THIS DOCUMENT AND ALL STATEMENTS THEREIN.

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE **DATE**

RELATIONSHIP TO THE PATIENT IF SIGNED BY ANYONE OTHER THAN HIM/HER (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)



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Date: ________ / ________ / ________

To whom it may concern:

I hereby authorize the release of my medical records to the address listed above.

Patient Name: ____

Patient Address: ____

____

Patient Date of Birth: ________ / ________ / ________

Patient Signature: ____

PREVIOUS PROVIDERS

Name/Facility ________________________________

Address: ____________________________________

Phone: ________________________

Fax: __________________________

Name/Facility ________________________________

Address: ____________________________________

Phone: ________________________

Fax: __________________________

Faxed for request on:____________________