COPPER RIVER
NATIVE ASSOCIATION

***Please return this completed form prior to your visit with a provider***

☐ **New Patient** ☐ **Update**

## Section 1: Patient Information

| | | |
|---|---|---|
| **Last Name** | **First Name** | **Middle Initial** |
| **Gender** ☐ Male ☐ Female ☐ Other | **Social Security Number** | **Birth Date** |
| **Mailing Address** | **City, State** | **Zip** |
| **Home Phone** | **Cell Phone** | **Message Phone** |
| **Marital Status** ☐ Single ☐ Married ☐ Other: _____ | **Homeless** ☐ Yes ☐ No | **Public Housing** ☐ Yes ☐ No |
| **Ethnicity / Race** ☐ Alaskan Native\Native American ☐ Non Native ☐ Hispanic | | |
| **Languages** | **Interpreter Required** | **Chaperone** |
| **Employment Status** ☐ Employed Full Time ☐ Employed Part Time ☐ Self Employed ☐ Retired ☐ Unemployed | | |
| **Employer Name** | **Employer Address** | **Employer Phone** |
| **Monthly Income** | **Household Income** | **Total People in Household** |
| **Emergency Contact Name** | **Emergency Contact Number** | **Emergency Contact Relationship** |

## Section 2: Guarantor/Legal Guardian

| | | |
|---|---|---|
| **Relationship to Patient** | | **Gender** |
| **Last Name** | **First Name** | **Birthdate** |
| **Mailing Address** | **City State** | **Zip** |

## Section 3: Primary and Secondary Insurance

| | | |
|---|---|---|
| **Insurance Company Name** | **Group Number** | **Subscriber ID Number** |
| **Subscribers Full Name** | **Employers Name** | **Co-Payment** |
| **Insurance Company Name** | **Group Number** | **Subscriber ID Number** |
| **Subscribers Full Name** | **Employers Name** | **Co-Payment** |

## Section 4: Acknowledgment

*Please Initial*

_____ **CONSENT TO CARE**
I consent to the plan of care proposed by the providers in the Primary Care Clinic at CRNA. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my health care and will make my wishes known. I understand that CRNA participates in the training of physicians and other healthcare providers and will be told when trainees take part in my care.

_____ **NOTIFICATION OF RELEASE FOR PAYMENT**
I understand that CRNA will disclose any diagnoses and pertinent information to the extent required at assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical, dental and behavioral health.

_____ **FINANCIAL AGREEMENT**
I understand that any applicable co-payments, discounts and prompt pay charges are due at time of service, including fees for services not covered by the I H S, if I am an eligible beneficiary. I assign payment from my insurance directly to CRNA. I understand I am financially responsible to CRNA for charges not paid by my insurance and that payment for those charges is due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills for laboratory, radiology, and other specialized services.

_____ **PAYMENT AGREEMENT**
I understand that CRNA, under certain circumstances, may offer me the opportunity to repay my portion of services provided under a payment agreement. I understand that this is a legally binding agreement and I am responsible to meet the terms of the agreement.

_____ **NOTICE OF PRIVACY PRACTICES**
I acknowledge and agree that I have received a copy of CRNA's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of this notice at any time.

*I have read the above and initialed my consent and financial responsibility for services at CRNA. If I have a question about my visits or any financial liability, I will contact CRNA registration prior to my appointment.*

Date: _____ Patient Signature _____

Guardian Signature _____

***OFFICE USE ONLY***

Staff Initials: _____

Patient MRN #: _____

Date Entered In CERNER: _____

☐ Patient refused to sign

☐ Communication barriers prohibited obtaining acknowledgment

☐ An emergency situation prohibited obtaining acknowledgment

☐ Other: _____

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# Health Summary

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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
| ☐ Chicken Pox | ☐ Crohn's Disease | ☐ Bladder Infections | ☐ Hepatitis | ☐ Heart Disease |
| ☐ Diphtheria | ☐ Ulcer | ☐ Kidney Disease | ☐ A ☐ B ☐ C | ☐ Aids/HIV |
| ☐ Smallpox | ☐ Glaucoma | ☐ Hernia | ☐ Blood/Plasma Transfusion | ☐ Fibromyalgia |
| ☐ Polio | ☐ Epilepsy | ☐ Back Trouble | ☐ Bruising | ☐ Bronchitis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ STD | ☐ Other: _____ | ☐ Stroke |
| ☐ Whooping Cough | ☐ Cancer | ☐ Head Injury | | ☐ Other:_____ |
| ☐ Pneumonia | ☐ Chronic Fatigue | ☐ Mitral Valve Prolapse | | ☐ Other: _____ |

**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
| **Caffeine Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Drug Use: Types** _____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Exercise Type:**_____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Traumatic Events:** |

**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Cancer** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Heart Disease** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Death Before Age 50** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |

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**General Health (Past Year)**
- ☐ Good
- ☐ Poor
- ☐ Recent Weight Change: _____lbs.
- ☐ Fatigue/Poor Energy
- ☐ Sleeping Problems/Snoring

**Ear/Nose/Mouth/Throat**
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Sinus Infections/Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath/Bad Taste
- ☐ Sore Throat
- ☐ Swollen Gland in Neck
- ☐ Voice Change

**Cardiovascular**
- ☐ Last Cholesterol Screen Date: _____
- ☐ Heart Trouble/Attack
- ☐ Chest Pain/ Angina
- ☐ Heart Medications
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Shortness of Breath at Rest
- ☐ Pain in Legs
- ☐ Swelling in Ankles
- ☐ Varicose Veins
- ☐ Cold Extremities

**Musculoskeletal/Pain**
- ☐ Muscles Aches/Cramping
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Joint Stiffness
- ☐ Difficulty Walking Standing
- ☐ Osteoporosis
- ☐ History of Injuries and Accidents

  Date:_____

  Details:_____

  Date:_____

  Details:_____

**Urinary Tract**
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Urgency/Burning/Painful Urination
- ☐ Blood In Urine
- ☐ Change in Urine Stream
- ☐ Incontinence or Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:_____

**Skin/Breast/Immune System**
- ☐ Rash/Itching/Hives
- ☐ Dry Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ New or Changing Moles
- ☐ Breast pain
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Allergies:

  ☐ Food ☐ Seasonal

  ☐ Environmental:_____

  ☐ Other: _____
- ☐ Immune Deficiency/Compromise

**Gastrointestinal**
- ☐ Colon Cancer Screen Date:_____
- ☐ Appetite:

  ☐ Good ☐ Poor ☐ Excessive
- ☐ Recent Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Heartburn/Reflux
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Bowel Movements: # Per Day _____

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- ☐ Change in Bowel Habits
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- ☐ Sinus Headaches
- ☐ Dizziness
- ☐ Light Headed
- ☐ Convulsions of Seizures
- ☐ Tremors
- ☐ Paralysis
- ☐ Numbness or Tingling
- ☐ Depression
- ☐ Anxiety/Nervousness
- ☐ Memory Loss/Confusion
- ☐ Abuse Survivor
- ☐ Trouble Sleeping

**Female**
- ☐ Last Period Start Date: _____
- ☐ Periods Are:

  ☐ Regular ☐ Irregular
- ☐ Monthly Cycle: # of Days _____
- ☐ PMS:

  ☐ Irritability

  ☐ Emotional

  ☐ Breast Tenderness/Swelling

  ☐ Other: _____
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _____
- ☐ # of Live Births: _____
- ☐ Menopause Symptoms:

  ☐ Hot Flashes

  ☐ Night Sweats

  ☐ Vaginal Dryness

  ☐ Other: _____
- ☐ Date of Last Mammogram: _____

  ☐ Normal ☐ Abnormal
- ☐ Date of Last PAP Smear:

  ☐ Normal ☐ Abnormal

**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Coughing Up Blood

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_____

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_____

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| | | | |
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| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
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- ☐ Blood In Urine
- ☐ Change in Urine Stream
- ☐ Incontinence or Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:_____

**Skin/Breast/Immune System**
- ☐ Rash/Itching/Hives
- ☐ Dry Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ New or Changing Moles
- ☐ Breast pain
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Allergies:

  ☐ Food ☐ Seasonal

  ☐ Environmental:_____

  ☐ Other: _____
- ☐ Immune Deficiency/Compromise

**Gastrointestinal**
- ☐ Colon Cancer Screen Date:_____
- ☐ Appetite:

  ☐ Good ☐ Poor ☐ Excessive
- ☐ Recent Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Heartburn/Reflux
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Bowel Movements: # Per Day _____

  ☐ Easy ☐ Difficult
- ☐ Skip Days of Moving Bowels
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding or Blood in Stool

**Eyes**
- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred Vision
- ☐ Double Vision

**Neurological/Psychological**
- ☐ Headaches

  ☐ Daily ☐ Weekly
- ☐ Migraines
- ☐ Sinus Headaches
- ☐ Dizziness
- ☐ Light Headed
- ☐ Convulsions of Seizures
- ☐ Tremors
- ☐ Paralysis
- ☐ Numbness or Tingling
- ☐ Depression
- ☐ Anxiety/Nervousness
- ☐ Memory Loss/Confusion
- ☐ Abuse Survivor
- ☐ Trouble Sleeping

**Female**
- ☐ Last Period Start Date: _____
- ☐ Periods Are:

  ☐ Regular ☐ Irregular
- ☐ Monthly Cycle: # of Days _____
- ☐ PMS:

  ☐ Irritability

  ☐ Emotional

  ☐ Breast Tenderness/Swelling

  ☐ Other: _____
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _____
- ☐ # of Live Births: _____
- ☐ Menopause Symptoms:

  ☐ Hot Flashes

  ☐ Night Sweats

  ☐ Vaginal Dryness

  ☐ Other: _____
- ☐ Date of Last Mammogram: _____

  ☐ Normal ☐ Abnormal
- ☐ Date of Last PAP Smear:

  ☐ Normal ☐ Abnormal

**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Coughing Up Blood

COPPER RIVER
NATIVE ASSOCIATION

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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
| ☐ Chicken Pox | ☐ Crohn's Disease | ☐ Bladder Infections | ☐ Hepatitis | ☐ Heart Disease |
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| ☐ Smallpox | ☐ Glaucoma | ☐ Hernia | ☐ Blood/Plasma Transfusion | ☐ Fibromyalgia |
| ☐ Polio | ☐ Epilepsy | ☐ Back Trouble | ☐ Bruising | ☐ Bronchitis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ STD | ☐ Other: _____ | ☐ Stroke |
| ☐ Whooping Cough | ☐ Cancer | ☐ Head Injury | | ☐ Other:_____ |
| ☐ Pneumonia | ☐ Chronic Fatigue | ☐ Mitral Valve Prolapse | | ☐ Other: _____ |

**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
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**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Cancer** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
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| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
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- ☐ Last Cholesterol Screen Date: _____
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- ☐ Joint Swelling
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- ☐ Joint Stiffness
- ☐ Difficulty Walking Standing
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Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

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**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

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**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
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Have you had problems with prior dental treatment: ☐ Yes ☐ No

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**Gastrointestinal**
- ☐ Colon Cancer Screen Date:_____
- ☐ Appetite:

  ☐ Good ☐ Poor ☐ Excessive
- ☐ Recent Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Heartburn/Reflux
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Bowel Movements: # Per Day _____

  ☐ Easy ☐ Difficult
- ☐ Skip Days of Moving Bowels
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding or Blood in Stool

**Eyes**
- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred Vision
- ☐ Double Vision

**Neurological/Psychological**
- ☐ Headaches

  ☐ Daily ☐ Weekly
- ☐ Migraines
- ☐ Sinus Headaches
- ☐ Dizziness
- ☐ Light Headed
- ☐ Convulsions of Seizures
- ☐ Tremors
- ☐ Paralysis
- ☐ Numbness or Tingling
- ☐ Depression
- ☐ Anxiety/Nervousness
- ☐ Memory Loss/Confusion
- ☐ Abuse Survivor
- ☐ Trouble Sleeping

**Female**
- ☐ Last Period Start Date: _____
- ☐ Periods Are:

  ☐ Regular ☐ Irregular
- ☐ Monthly Cycle: # of Days _____
- ☐ PMS:

  ☐ Irritability

  ☐ Emotional

  ☐ Breast Tenderness/Swelling

  ☐ Other: _____
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _____
- ☐ # of Live Births: _____
- ☐ Menopause Symptoms:

  ☐ Hot Flashes

  ☐ Night Sweats

  ☐ Vaginal Dryness

  ☐ Other: _____
- ☐ Date of Last Mammogram: _____

  ☐ Normal ☐ Abnormal
- ☐ Date of Last PAP Smear:

  ☐ Normal ☐ Abnormal

**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Coughing Up Blood

COPPER RIVER
NATIVE ASSOCIATION

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# Health Summary

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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
| ☐ Chicken Pox | ☐ Crohn's Disease | ☐ Bladder Infections | ☐ Hepatitis | ☐ Heart Disease |
| ☐ Diphtheria | ☐ Ulcer | ☐ Kidney Disease | ☐ A ☐ B ☐ C | ☐ Aids/HIV |
| ☐ Smallpox | ☐ Glaucoma | ☐ Hernia | ☐ Blood/Plasma Transfusion | ☐ Fibromyalgia |
| ☐ Polio | ☐ Epilepsy | ☐ Back Trouble | ☐ Bruising | ☐ Bronchitis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ STD | ☐ Other: _____ | ☐ Stroke |
| ☐ Whooping Cough | ☐ Cancer | ☐ Head Injury | | ☐ Other:_____ |
| ☐ Pneumonia | ☐ Chronic Fatigue | ☐ Mitral Valve Prolapse | | ☐ Other: _____ |

**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
| **Caffeine Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Drug Use: Types** _____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Exercise Type:**_____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Traumatic Events:** |

**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Cancer** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Heart Disease** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Death Before Age 50** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |

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**General Health (Past Year)**
- ☐ Good
- ☐ Poor
- ☐ Recent Weight Change: _____lbs.
- ☐ Fatigue/Poor Energy
- ☐ Sleeping Problems/Snoring

**Ear/Nose/Mouth/Throat**
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Sinus Infections/Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath/Bad Taste
- ☐ Sore Throat
- ☐ Swollen Gland in Neck
- ☐ Voice Change

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- ☐ Last Cholesterol Screen Date: _____
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- ☐ Chest Pain/ Angina
- ☐ Heart Medications
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Shortness of Breath at Rest
- ☐ Pain in Legs
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- ☐ Varicose Veins
- ☐ Cold Extremities

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- ☐ Muscles Aches/Cramping
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- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Joint Stiffness
- ☐ Difficulty Walking Standing
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- ☐ History of Injuries and Accidents

  Date:_____

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**Urinary Tract**
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Urgency/Burning/Painful Urination
- ☐ Blood In Urine
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- ☐ Incontinence or Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:_____

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- ☐ Rash/Itching/Hives
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- ☐ New or Changing Moles
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**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

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**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

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**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
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Are you in pain now? ☐ Yes ☐ No

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| | | | | |
|---|---|---|---|---|
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| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
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**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

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_____

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| | | | |
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  ☐ Daily ☐ Weekly
- ☐ Migraines
- ☐ Sinus Headaches
- ☐ Dizziness
- ☐ Light Headed
- ☐ Convulsions of Seizures
- ☐ Tremors
- ☐ Paralysis
- ☐ Numbness or Tingling
- ☐ Depression
- ☐ Anxiety/Nervousness
- ☐ Memory Loss/Confusion
- ☐ Abuse Survivor
- ☐ Trouble Sleeping

**Female**
- ☐ Last Period Start Date: _____
- ☐ Periods Are:

  ☐ Regular ☐ Irregular
- ☐ Monthly Cycle: # of Days _____
- ☐ PMS:

  ☐ Irritability

  ☐ Emotional

  ☐ Breast Tenderness/Swelling

  ☐ Other: _____
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _____
- ☐ # of Live Births: _____
- ☐ Menopause Symptoms:

  ☐ Hot Flashes

  ☐ Night Sweats

  ☐ Vaginal Dryness

  ☐ Other: _____
- ☐ Date of Last Mammogram: _____

  ☐ Normal ☐ Abnormal
- ☐ Date of Last PAP Smear:

  ☐ Normal ☐ Abnormal

**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Coughing Up Blood

COPPER RIVER
NATIVE ASSOCIATION

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# Health Summary

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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
| ☐ Chicken Pox | ☐ Crohn's Disease | ☐ Bladder Infections | ☐ Hepatitis | ☐ Heart Disease |
| ☐ Diphtheria | ☐ Ulcer | ☐ Kidney Disease | ☐ A ☐ B ☐ C | ☐ Aids/HIV |
| ☐ Smallpox | ☐ Glaucoma | ☐ Hernia | ☐ Blood/Plasma Transfusion | ☐ Fibromyalgia |
| ☐ Polio | ☐ Epilepsy | ☐ Back Trouble | ☐ Bruising | ☐ Bronchitis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ STD | ☐ Other: _____ | ☐ Stroke |
| ☐ Whooping Cough | ☐ Cancer | ☐ Head Injury | | ☐ Other:_____ |
| ☐ Pneumonia | ☐ Chronic Fatigue | ☐ Mitral Valve Prolapse | | ☐ Other: _____ |

**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
| **Caffeine Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Drug Use: Types** _____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Exercise Type:**_____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Traumatic Events:** |

**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Cancer** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Heart Disease** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Death Before Age 50** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |

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**General Health (Past Year)**
- ☐ Good
- ☐ Poor
- ☐ Recent Weight Change: _____lbs.
- ☐ Fatigue/Poor Energy
- ☐ Sleeping Problems/Snoring

**Ear/Nose/Mouth/Throat**
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Sinus Infections/Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath/Bad Taste
- ☐ Sore Throat
- ☐ Swollen Gland in Neck
- ☐ Voice Change

**Cardiovascular**
- ☐ Last Cholesterol Screen Date: _____
- ☐ Heart Trouble/Attack
- ☐ Chest Pain/ Angina
- ☐ Heart Medications
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Shortness of Breath at Rest
- ☐ Pain in Legs
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**Musculoskeletal/Pain**
- ☐ Muscles Aches/Cramping
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- ☐ Joint Swelling
- ☐ Low Back Pain
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- ☐ Joint Stiffness
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- ☐ History of Injuries and Accidents

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- ☐ Nighttime Urination
- ☐ Urgency/Burning/Painful Urination
- ☐ Blood In Urine
- ☐ Change in Urine Stream
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- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:_____

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- ☐ Rash/Itching/Hives
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- ☐ Eczema
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- ☐ New or Changing Moles
- ☐ Breast pain
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Allergies:

  ☐ Food ☐ Seasonal

  ☐ Environmental:_____

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- ☐ Colon Cancer Screen Date:_____
- ☐ Appetite:

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- ☐ Recent Change in Appetite
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- ☐ Heartburn/Reflux
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- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contacts
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**Allergies:**_____ **Last Physical:**_____

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Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

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**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

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**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
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Details:_____

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- ☐ # of Pregnancies: _____
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Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

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|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
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_____

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  - ☐ Irritability
  - ☐ Emotional
  - ☐ Breast Tenderness/Swelling
  - ☐ Other: _____
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _____
- ☐ # of Live Births: _____
- ☐ Menopause Symptoms:
  - ☐ Hot Flashes
  - ☐ Night Sweats
  - ☐ Vaginal Dryness
  - ☐ Other: _____
- ☐ Date of Last Mammogram: _____
  - ☐ Normal ☐ Abnormal
- ☐ Date of Last PAP Smear:
  - ☐ Normal ☐ Abnormal

**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Coughing Up Blood

COPPER RIVER
NATIVE ASSOCIATION

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# Health Summary

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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
| ☐ Chicken Pox | ☐ Crohn's Disease | ☐ Bladder Infections | ☐ Hepatitis | ☐ Heart Disease |
| ☐ Diphtheria | ☐ Ulcer | ☐ Kidney Disease | ☐ A ☐ B ☐ C | ☐ Aids/HIV |
| ☐ Smallpox | ☐ Glaucoma | ☐ Hernia | ☐ Blood/Plasma Transfusion | ☐ Fibromyalgia |
| ☐ Polio | ☐ Epilepsy | ☐ Back Trouble | ☐ Bruising | ☐ Bronchitis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ STD | ☐ Other: _____ | ☐ Stroke |
| ☐ Whooping Cough | ☐ Cancer | ☐ Head Injury | | ☐ Other:_____ |
| ☐ Pneumonia | ☐ Chronic Fatigue | ☐ Mitral Valve Prolapse | | ☐ Other: _____ |

**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
| **Caffeine Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Drug Use: Types** _____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Exercise Type:**_____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Traumatic Events:** |

**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Cancer** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Heart Disease** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Death Before Age 50** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |

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**General Health (Past Year)**
- ☐ Good
- ☐ Poor
- ☐ Recent Weight Change: _____lbs.
- ☐ Fatigue/Poor Energy
- ☐ Sleeping Problems/Snoring

**Ear/Nose/Mouth/Throat**
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Sinus Infections/Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath/Bad Taste
- ☐ Sore Throat
- ☐ Swollen Gland in Neck
- ☐ Voice Change

**Cardiovascular**
- ☐ Last Cholesterol Screen Date: _____
- ☐ Heart Trouble/Attack
- ☐ Chest Pain/ Angina
- ☐ Heart Medications
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Shortness of Breath at Rest
- ☐ Pain in Legs
- ☐ Swelling in Ankles
- ☐ Varicose Veins
- ☐ Cold Extremities

**Musculoskeletal/Pain**
- ☐ Muscles Aches/Cramping
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Joint Stiffness
- ☐ Difficulty Walking Standing
- ☐ Osteoporosis
- ☐ History of Injuries and Accidents

Date:_____

Details:_____

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**Urinary Tract**
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Urgency/Burning/Painful Urination
- ☐ Blood In Urine
- ☐ Change in Urine Stream
- ☐ Incontinence or Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:_____

**Skin/Breast/Immune System**
- ☐ Rash/Itching/Hives
- ☐ Dry Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ New or Changing Moles
- ☐ Breast pain
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Allergies:
  - ☐ Food ☐ Seasonal
  - ☐ Environmental:_____
  - ☐ Other: _____
- ☐ Immune Deficiency/Compromise

**Gastrointestinal**
- ☐ Colon Cancer Screen Date:_____
- ☐ Appetite:
  - ☐ Good ☐ Poor ☐ Excessive
- ☐ Recent Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Heartburn/Reflux
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Bowel Movements: # Per Day _____
  - ☐ Easy ☐ Difficult
- ☐ Skip Days of Moving Bowels
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding or Blood in Stool

**Eyes**
- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contacts
- ☐ Blurred Vision
- ☐ Double Vision

**Neurological/Psychological**
- ☐ Headaches
  - ☐ Daily ☐ Weekly
- ☐ Migraines
- ☐ Sinus Headaches
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- ☐ Convulsions of Seizures
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- ☐ Depression
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- ☐ Last Period Start Date: _____
- ☐ Periods Are:
  - ☐ Regular ☐ Irregular
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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
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**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
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**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

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  - ☐ Breast Tenderness/Swelling
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- ☐ # of Pregnancies: _____
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Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

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|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
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_____

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_____

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| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
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  - ☐ Vaginal Dryness
  - ☐ Other: _____
- ☐ Date of Last Mammogram: _____
  - ☐ Normal ☐ Abnormal
- ☐ Date of Last PAP Smear:
  - ☐ Normal ☐ Abnormal

**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Coughing Up Blood

COPPER RIVER
NATIVE ASSOCIATION

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# Health Summary

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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
| ☐ Chicken Pox | ☐ Crohn's Disease | ☐ Bladder Infections | ☐ Hepatitis | ☐ Heart Disease |
| ☐ Diphtheria | ☐ Ulcer | ☐ Kidney Disease | ☐ A ☐ B ☐ C | ☐ Aids/HIV |
| ☐ Smallpox | ☐ Glaucoma | ☐ Hernia | ☐ Blood/Plasma Transfusion | ☐ Fibromyalgia |
| ☐ Polio | ☐ Epilepsy | ☐ Back Trouble | ☐ Bruising | ☐ Bronchitis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ STD | ☐ Other: _____ | ☐ Stroke |
| ☐ Whooping Cough | ☐ Cancer | ☐ Head Injury | | ☐ Other:_____ |
| ☐ Pneumonia | ☐ Chronic Fatigue | ☐ Mitral Valve Prolapse | | ☐ Other: _____ |

**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
| **Caffeine Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Drug Use: Types** _____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Exercise Type:**_____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Traumatic Events:** |

**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Cancer** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Heart Disease** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Death Before Age 50** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |

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- ☐ Good
- ☐ Poor
- ☐ Recent Weight Change: _____lbs.
- ☐ Fatigue/Poor Energy
- ☐ Sleeping Problems/Snoring

**Ear/Nose/Mouth/Throat**
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Sinus Infections/Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath/Bad Taste
- ☐ Sore Throat
- ☐ Swollen Gland in Neck
- ☐ Voice Change

**Cardiovascular**
- ☐ Last Cholesterol Screen Date: _____
- ☐ Heart Trouble/Attack
- ☐ Chest Pain/ Angina
- ☐ Heart Medications
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Shortness of Breath at Rest
- ☐ Pain in Legs
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- ☐ Varicose Veins
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**Musculoskeletal/Pain**
- ☐ Muscles Aches/Cramping
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Joint Stiffness
- ☐ Difficulty Walking Standing
- ☐ Osteoporosis
- ☐ History of Injuries and Accidents

Date:_____

Details:_____

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**Urinary Tract**
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Urgency/Burning/Painful Urination
- ☐ Blood In Urine
- ☐ Change in Urine Stream
- ☐ Incontinence or Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:_____

**Skin/Breast/Immune System**
- ☐ Rash/Itching/Hives
- ☐ Dry Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ New or Changing Moles
- ☐ Breast pain
- ☐ Breast Discharge
- ☐ Breast Lump
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  - ☐ Food ☐ Seasonal
  - ☐ Environmental:_____
  - ☐ Other: _____
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- ☐ Colon Cancer Screen Date:_____
- ☐ Appetite:
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- ☐ Recent Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Heartburn/Reflux
- ☐ Abdominal Pain
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**Eyes**
- ☐ Eye Disease or Injury
- ☐ Wear Glasses/Contacts
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- ☐ Last Period Start Date: _____
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  - ☐ Emotional
  - ☐ Breast Tenderness/Swelling
  - ☐ Other: _____
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _____
- ☐ # of Live Births: _____
- ☐ Menopause Symptoms:
  - ☐ Hot Flashes
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**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

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**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
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  - ☐ Emotional
  - ☐ Breast Tenderness/Swelling
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Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

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| | | | | |
|---|---|---|---|---|
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***Please return this completed form prior to your visit with a provider***

# Health Summary

*As a new patient and to help us understand any health issues that you may have, please fill out the information below to the best of your ability. We ask that you complete this form on annual basis so that we can provide you with exceptional care and monitor any changes in your health. All information is strictly confidential.*

**Patient Name**:_____ **Date of Birth**:_____ **Intake Date**:_____

**Chief Complaint:**_____

**Allergies:**_____ **Last Physical:**_____

**DENTAL SECTION** **Last Dental Exam:**_____

Have you had problems with prior dental treatment: ☐ Yes ☐ No

Are you in pain now? ☐ Yes ☐ No

Have you ever taken Bisphosphonates: ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Reclast/Zometa

**Patient Medical History** *Please check all that apply. Leave blank if unsure.*

| | | | | |
|---|---|---|---|---|
| ☐ Measles | ☐ Hemorrhoids | ☐ Herpes | ☐ High/Low Blood Pressure | ☐ Anemia |
| ☐ Mumps | ☐ IBS/Diverticulitis | ☐ Tuberculosis | ☐ Infectious Mono | ☐ Arthritis |
| ☐ Chicken Pox | ☐ Crohn's Disease | ☐ Bladder Infections | ☐ Hepatitis | ☐ Heart Disease |
| ☐ Diphtheria | ☐ Ulcer | ☐ Kidney Disease | ☐ A ☐ B ☐ C | ☐ Aids/HIV |
| ☐ Smallpox | ☐ Glaucoma | ☐ Hernia | ☐ Blood/Plasma Transfusion | ☐ Fibromyalgia |
| ☐ Polio | ☐ Epilepsy | ☐ Back Trouble | ☐ Bruising | ☐ Bronchitis |
| ☐ Rheumatic Fever | ☐ Diabetes | ☐ STD | ☐ Other: _____ | ☐ Stroke |
| ☐ Whooping Cough | ☐ Cancer | ☐ Head Injury | | ☐ Other:_____ |
| ☐ Pneumonia | ☐ Chronic Fatigue | ☐ Mitral Valve Prolapse | | ☐ Other: _____ |

**Previous Hospitalizations/Surgeries/Serious Illness/ Traumatic Events and Dates:** _____

_____

**Medications:** **(Include inhalers, herbs, supplements and over-the-counter items):** _____

_____

**Patient Social History:**

| | | | |
|---|---|---|---|
| **Marital Status**<br>☐ Single ☐ Separated<br>☐ Married ☐ Widowed<br>☐ Divorced | **Alcohol Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Smoking**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ | **Smokeless Tobacco**<br>☐ Never ☐ Currently<br>Amount Per Day: _____<br>☐ Previously, but quit on date:<br>_____ |
| **Caffeine Use**<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Drug Use: Types** _____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Exercise Type:**_____<br>☐ Never ☐ Rarely<br>☐ Moderate ☐ Regularly<br>Amount Per Day: _____ | **Traumatic Events:** |

**Family Medical History:** *Please check if a family member has had any of the following and check the relationship to you;*

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Cancer** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Heart Disease** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Hypertension** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |
| **Death Before Age 50** | ☐ Grandparent | ☐ Mother | ☐ Father | ☐ Sibling | ☐ Child |

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**General Health (Past Year)**
- ☐ Good
- ☐ Poor
- ☐ Recent Weight Change: _____lbs.
- ☐ Fatigue/Poor Energy
- ☐ Sleeping Problems/Snoring

**Ear/Nose/Mouth/Throat**
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Sinus Infections/Problems
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Bad Breath/Bad Taste
- ☐ Sore Throat
- ☐ Swollen Gland in Neck
- ☐ Voice Change

**Cardiovascular**
- ☐ Last Cholesterol Screen Date: _____
- ☐ Heart Trouble/Attack
- ☐ Chest Pain/ Angina
- ☐ Heart Medications
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Shortness of Breath at Rest
- ☐ Pain in Legs
- ☐ Swelling in Ankles
- ☐ Varicose Veins
- ☐ Cold Extremities

**Musculoskeletal/Pain**
- ☐ Muscles Aches/Cramping
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Joint Stiffness
- ☐ Difficulty Walking Standing
- ☐ Osteoporosis
- ☐ History of Injuries and Accidents

Date:_____

Details:_____

Date:_____

Details:_____

**Urinary Tract**
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Urgency/Burning/Painful Urination
- ☐ Blood In Urine
- ☐ Change in Urine Stream
- ☐ Incontinence or Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Male: Testicle Pain
- ☐ Male: Last Prostate Check:_____

**Skin/Breast/Immune System**
- ☐ Rash/Itching/Hives
- ☐ Dry Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ New or Changing Moles
- ☐ Breast pain
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Allergies:
  - ☐ Food ☐ Seasonal
  - ☐ Environmental:_____
  - ☐ Other: _____
- ☐ Immune Deficiency/Compromise

**Gastrointestinal**
- ☐ Colon Cancer Screen Date:_____
- ☐ Appetite:
  - ☐ Good ☐ Poor ☐ Excessive
- ☐ Recent Change in Appetite
- ☐ Nausea or Vomiting
- ☐ Heartburn/Reflux
- ☐ Abdominal Pain
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- ☐ Bowel Movements: # Per Day _____
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- ☐ Last Period Start Date: _____
- ☐ Periods Are:
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- ☐ Monthly Cycle: # of Days _____
- ☐ PMS:
  - ☐ Irritability
  - ☐ Emotional
  - ☐ Breast Tenderness/Swelling
  - ☐ Other: _____
- ☐ Vaginal Discharge or Itching
- ☐ # of Pregnancies: _____
- ☐ # of Live Births: _____
- ☐ Menopause Symptoms:
  - ☐ Hot Flashes
  - ☐ Night Sweats
  - ☐ Vaginal Dryness
  - ☐ Other: _____
- ☐ Date of Last Mammogram: _____
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**Respiratory**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
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COPPER RIVER
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