Section 1—Demographic Information

Primary Care Physician:	How were you referred:	
Name (Last, First, M.I.):	A.K.A.:	
Date of Birth: / /	Age:	Gender: Male Female Transgender Other
Mailing Address:		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
E-mail Address:	Do we have permission to contact you via e-mail? Yes No	

Primary Spoken Language: English Spanish Portuguese Other:	To which racial or ethnic group(s) do you *most* identify: African-American (non-Hispanic) Asian/Pacific Islanders Caucasian (non-Hispanic) Latino or Hispanic Native American or Aleut Other:

Marital Status: Single Partnered Married Separated Divorced Widowed	Full name of spouse or significant other:	
Employer Name:	Employer Address:	Occupation:
Employment Status (choose all that apply): Full-time Part-time Self-employed Not employed Retired Active Military		Driver's License Number:

Section 2—Emergency Contact Information

Contact Name:	Relation to Patient:	
Address:		
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

Section 3—Insurance Information: if we have a copy of your Ins. card(s) skip this section

Primary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Secondary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Other Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Section 4—Consents

☐ I hereby certify that I am eligible for the health insurance plan I have listed in my registration form. I, also, certify that I have chosen The Priority Care Center to provide me with healthcare services. I understand that, were the aforementioned statement not true, I would be responsible for any and all charges for the services rendered. Additionally, if the aforementioned statement were not true, I agree to pay all charges, in their entirety, and within 90 days of receiving an invoice for services rendered at the Priority Care Center.

☐ I understand my rights that are referenced in the notice of Privacy Practices (a copy of this can be made available to you upon request).

☐ I give consent to for The Priority Care Center to obtain my prescription history.

Signature_____ Date_____/_____/_____

Name_____ DOB _____

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Name: _____ DOB: _____ Gender: ☐M ☐F

Primary Care Provider: _____

Preferred Pharmacy: _____Location: _____

CURRENT MEDICATIONS/SUPPLEMENTS (may bring own list to visit if you prefer) – this information may be taken directly from the pharmacy label on the prescription product.

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

Past Medical History (Check all that apply)

☐ Acid Reflux/GERD	□ Chronic Pain	□ High Blood Pressure
□ ADHD	□ Depression	□ High Cholesterol
□ Alcoholism	□ Diabetes	□ Irritable Bowel
□ Allergies	□ Emphysema/Bronchitis/COPD	□ Kidney Disease
□ Anemia	□ Epilepsy/Seizure Disorder	□ Liver Disease
□ Anxiety	□ Glaucoma/Cataracts	☐Osteoporosis
□ Arthritis	□ Headaches	□ Stroke
□ Asthma	□ Hearing Loss	□ Thyroid Disease
☐ Bleeding Disorders	□ Heart Disease	□ Other: _____
□ Cancer		

Allergies

□ No Known Allergies	□ Medication Allergies	□ Environmental/ Seasonal Allergies	□ Latex Allergy

List Allergies	Reaction

Name_____ DOB _____

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Past Surgical History

Date of Surgery	Type of Surgery

Family Medical History

Members	Status (Alive/Deceased)	Diabetes	High blood pressure	Heart Disease	Mental Illness	Cancer (Type)	High cholesterol	Unknown
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Siblings								
Children								

Social History

Tobacco Use: Current use: ☐Yes ☐No
Past Use: ☐Yes ☐No When did you quit? _____
Type: ☐Cigarettes ☐Cigars ☐Chew ☐E-cigarette
Recreational Drug Use: ☐Yes ☐No
Type: ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamine ☐Other_____
Alcohol Use: ☐Daily ☐4-5 times per week ☐1-3 times per week ☐less than one time per week ☐none
Type: ☐Beer ☐Wine ☐Liquor
Marital Status: ☐Married ☐Separated ☐Divorced ☐Domestic Partnership ☐Single ☐Widow/Widower
Living Situation: ☐Own ☐Rent ☐Homeless ☐Other _____
Children: ☐Yes ☐No if yes, do they live with you ☐Yes ☐No
Support Network: ☐Spouse/Significant other ☐Family ☐Friends ☐Counselor ☐Other _____
Diet/Exercise: Are you on a special diet? ☐Yes ☐No if yes, what type _____
Do you Exercise? ☐Yes ☐No If yes, how often ☐Daily ☐3-5 days per week
☐1-2 days per week ☐less than once per week
What type _____

Name_____ DOB _____

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Do you have an Advance Directive in place?
☐Living Will ☐Durable Power of Attorney ☐Advanced Directive ☐POLST ☐None

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients			
Last Tetanus Booster	□ Within past 10 years	□ More than 10 years ago	□ Unknown
Last Eye Exam (Dilated or Retinal) Last Hearing Exam Last Dental Exam Last Foot Exam	Date: _____ Date: _____ Date: _____ Date: _____	□ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal	□ Unknown □ Unknown □ Unknown □ Unknown
Last colonoscopy/ sigmoidoscopy/Or stool test	Date: _____	□ Normal □ Abnormal	□ Unknown
Last DEXA Bone Scan Last Pneumonia Vaccine Flu shot this season?	Date: _____ Date: _____ □ Yes □ No	□ Normal □ Abnormal	□ Unknown
Women Only			
Last Pap Smear	Date: _____	□ Normal □ Abnormal	□ Unknown
Last Mammogram	Date:	□ Normal □ Abnormal	□ Unknown

Concerns
Please indicate any concerns regarding your health in the space provided

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NAME: _____

Date: _____

PHQ-9	*Over the **last 2 weeks** how often have you been bothered by any of the following problems?*	*not at all*	*several days*	*more than half the days*	*nearly every day*
1.	Little interest or pleasure in doing things	*0*	*1*	*2*	*3*
2.	Feeling down, depressed, or hopeless	*0*	*1*	*2*	*3*
3.	Trouble falling or staying asleep, or sleeping too much	*0*	*1*	*2*	*3*
4.	Feeling tired or having little energy	*0*	*1*	*2*	*3*
5.	Poor appetite or overeating	*0*	*1*	*2*	*3*
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	*0*	*1*	*2*	*3*
7.	Trouble concentrating on things, such as reading the newspaper or watching television	*0*	*1*	*2*	*3*
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	*0*	*1*	*2*	*3*
9.	Thoughts that you would be better off dead or of hurting yourself in some way	*0*	*1*	*2*	*3*
	PHQ-9 total score =				

Would you like someone from our office to contact you before your appointment regarding any of the above?

____Yes _____No

Are you currently undergoing any treatment for depression?

□ **Medications:** _____

□ **Counselor:** _____

□ **Other:** _____

Client Name: _____ DOB: _____ Date obtained: _____

(PROMIS) Patient Reported Outcomes Measurement Information System is a system of highly reliable, precise measures of patient–reported health status for physical, mental, and social well–being. PROMIS tools measure what patients are able to do and how they feel by asking questions.

Global Health Assessment

Please respond to each item by marking one box per row. (NOTE: One or more missing responses will render such scoring unusable).

Questions	Excellent (5)	Very Good (4)	Good (3)	Fair (2)	Poor (1)
Global 01: In General, would you say your health is					
Global 02: In general, would you say your quality of life is					
Global 03: In general, how would you rate your physical health?					
Global 04: In general, how would you rate your mental health, including your mood and your ability to think?					
Global 05: In general, how would you rate your satisfaction with your social activities and relationships?					
Global 09: In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.					
	Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global 06: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?					
	Never	**Rarely**	**Sometimes**	**Often**	**Always**
Global 10: In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?					
	None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global 08: How would you rate your fatigue on Average?					
Global 07: How would you rate your pain on average?	☐ 0	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9	☐ 10
To be completed by staff: Total Score (G03, 06, 07, 08) Total Score (G02, 04, 05, 10)					_____

GESTATIONAL DIABETES HISTORY

Name:

DOB:

MR#: HCL#:

Attach label or addressograph

Obstetrician/Primary care provider name | Provider phone #

Obstetrician/Provider's address

Pharmacy name | Pharmacy phone #

Marital status
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Cohabitating

# of people in household

Will significant others participate in program?
☐ No ☐ Yes ► Relationships: _____ Names: _____

Race/Ethnicity (check all that apply)
☐ White ☐ Native American ☐ Black or African American ☐ Multi-race
☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian or other Pacific Islander

What level of schooling have you completed?
☐ Elementary school ☐ High school diploma ☐ Some college ☐ College/University degree
☐ Technical/Vocational/Business ☐ Military training ☐ Graduate school ☐ Other: _____

Occupation
☐ Technical/Sales/Clerical ☐ Unemployed ☐ Homemaker ☐ Other: _____
☐ Skilled labor ☐ Student ☐ Managerial/Professional _____
☐ Other labor ☐ Military ☐ Education/Teacher

Do you have any medication allergies?
☐ No ☐ Yes ► What kind? _____

Have you ever been diagnosed with any of the following conditions, or do you have a concern?

Diagnosed	Concern	Diagnosed	Concern	Diagnosed	Concern
☐	☐ High blood pressure	☐	☐ Thyroid disease	☐	☐ Stomach or bowel problems
☐	☐ Heart disease	☐	☐ Eye or vision problems	☐	☐ Depression
☐	☐ Abnormal blood lipids (fats)	☐	☐ Kidney disease		
☐	☐ Circulation problems	☐	☐ Skin	**Family history of:**	
☐	☐ Numbness/Pain (hands/legs/feet)	☐	☐ Dental or mouth problems	Diabetes	☐ No ☐ Yes
☐	☐ Foot problems	☐	☐ Liver disease	Thyroid disease	☐ No ☐ Yes
				Heart disease	☐ No ☐ Yes

List past surgeries and/or hospitalizations with dates (not including child birth):

Surgery/Hospitalization: _____ Date: _____

Surgery/Hospitalization: _____ Date: _____

Surgery/Hospitalization: _____ Date: _____

PRIOR PREGNANCY HISTORY

How many full-term deliveries have you had?

How many premature births have you had?

How many abortions/miscarriages have you had?

Have you had any complications in prior pregnancies? ☐ No ☐ Yes
► If yes, explain: _____

Have you ever had gestational diabetes in the past? ☐ No ☐ Yes
► If yes, did you take: ☐ Glyburide ☐ Insulin ☐ Other: _____

List your living children:

Name	Age	Birth weight	Was the baby full-term or premature?

GESTATIONAL DIABETES HISTORY (Cont): NUTRITION AND LIFESTYLE HISTORY

Have you used any food planning methods in the past (such as carb counting, exchange lists, commercial weight loss programs, etc.)? If so, please list:

Typical day schedule: Please fill in the **times** of your meals and snacks, along with an example of the **type and amount** of food and drink you might have for your meals and snacks.

	TIME	TYPICAL MEALS AND SNACKS
I get up at		
Breakfast		Breakfast meal:
Morning snack		Morning snack:
Midday meal		Midday meal:
Afternoon snack		Afternoon snack:
Evening meal		Evening meal:
Evening/Bedtime snack		Evening/Bedtime snack:
I go to bed at		

Is your job active or inactive?
☐ Active ☐ Inactive ► Explain: _____

Do you exercise?
☐ No ☐ Yes ► What type(s)? ☐ Walking ☐ Biking ☐ Active job ☐ Swimming ☐ Sports ☐ Aerobic machine ☐ Other: _____

How many times per week do you exercise?
☐ 0 ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ More than 6

For how many minutes per time?
☐ 0 ☐ 1–10 ☐ 11–15 ☐ 16–30 ☐ More than 30

Have you been advised by a physician to limit your exercise during pregnancy?
☐ No ☐ Yes ► Explain: _____

What was your weight before this pregnancy? | Is weight gain a concern for you? ☐ No ☐ Yes

Do you have any problems with nausea or vomitting? ☐ No ☐ Yes

Do you have any other nutrition concerns? ☐ No ☐ Yes
► If yes, explain: _____

Do you drink alcohol?
☐ No ☐ Yes ► Type(s), amount, and times per week: _____

Do you use tobacco?
☐ No ☐ Yes ► Type: _____ Amount per day: _____

Former tobacco user?
☐ No ☐ Yes ► Quit date? _____ | Do you use street drugs?
☐ No ☐ Yes

List all of your medications, including over-the-counter medications, prenatal vitamins, and other vitamin/mineral supplements:

_____

_____

_____

_____

GESTATIONAL DIABETES HISTORY (Cont): LIFESTYLE AND BEHAVIORAL ASSESSMENT

MOST IMPORTANT CONCERNS

What do you feel are your most important concerns in regard to managing your gestational diabetes?
What would you like to learn during your visits?

Check each of the items below that may concern you.

- ☐ 1. Do you have concerns about sleeping (such as insomnia, sleep apnea, nightmares, talking in your sleep)?
- ☐ 2. Do you have concerns about eating or exercising (such as eating too little, overeating, over-exercising)?
- ☐ 3. Do you have concerns about possible depression or noticeable mood changes (such as feeling sad, having mood swings, increased irritability)?
- ☐ 4. Do you have concerns about anxiety, nervousness, or stress (such as feeling worried all the time, over-stressed)?
- ☐ 5. Do you have concerns about problems in social, school, or work environments (such as decreased productivity, avoidance, withdrawal)?
- ☐ 6. Do you have concerns about relationships with other people (such as friends, people at school, people at work)?
- ☐ 7. Do you have concerns about family issues (such as conflict, marital conflict, issues concerning the baby's father, disciplining children)?
- ☐ 8. Do you have concerns about financial issues (such as healthcare insurance, support for the baby, paying for infant supplies)?
- ☐ 9. Do you have concerns about problem behaviors (such as aggression, overactivity, repeating behaviors you do not want to repeat, illegal behavior)?
- ☐ 10. Do you have problems with addictive behaviors (such as drug or alcohol abuse, gambling, workaholic behavior)?
- ☐ 11. Have you ever worked with a counselor or psychologist?
  - ☐ No ☐ Yes ►What was helpful? Please explain: _____
  - _____
  - _____
- ☐ 12. Would you like a referral to a counselor or psychologist?
  - ☐ No ☐ Yes

Who completed this form?	Relationship to patient
Signature	

FOR HEALTH PROFESSIONAL USE

- ☐ Referral made and accepted
- ☐ Referral made and declined
- ☐ Referral pending