Santa Barbara Doctor

Barbara A. Hrach, M.D., FACP

Karina Garcia, M.D.

Internal Medicine

229 W. Pueblo St. Santa Barbara, CA 93105

(805) 898-0500

www.santabarbaradoctor.net

General Information____Please Print

Personal Information:

Name:____ Date of Birth:_____/____/_____

Address: ____

City: ___________________________________ Zip Code:_______________ Gender:

Preferred Phone: ______________________________________ Please Select :

Is it okay to leave a private message on the preferred phone:

Alternative Phone: _____________________________________Please Select:

Email:____________________________________ Social Security #:______ /_____ /______

Employment Information:

Place of Employment:____________________________________ Phone:____________________________

May we contact you at work? Yes_____ No______

Emergency Contact Information:

Name:________________________________Address:____

City:__________________________ Zip Code:_____________ Phone:______________________________

Relationship to Patient? ________________________________

Insurance Information: *Please provide receptionist with your insurance card so we can make a copy for our records.*

Circle Reminder Preference: Phone Email Mail Fax

Circle Language: Dutch English French Spanish Japanese

Circle Race: American Indian Asian African American White Hawaiian or Pacific Islander

Circle Ethnicity: Hispanic or Latino Not Hispanic or Latino

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Patient Health Questionnaire:

We would like to get to know you. Please Print.

Primary reason for today's visit: ____

Medication Allergies: ____

Current Medications: Please list ALL medicines including over the counter and supplements

Name	Dose	Times taken Daily

Pharmacy Information:

Name: ____

Address: ____

Patient Name: ____ **Date:** ____________________

Santa Barbara Doctor

Review of Systems:

Please mark **YES** if you have any of the following.

	YES			YES
General			**Respiratory**	
Weight gain			Shortness of breath	
Weight loss			Cough	
Memory loss			Wheezing	
Fatigue			Sputum	
Fever/chills				
Night sweats			**Cardiac**	
Change in appetite			Chest pain	
			Palpitations	
Eyes			Murmur	
Glasses			Leg swelling	
Contact Lenses				
Blurriness			**Gastrointestinal**	
Tearing			Heartburn	
Itching			Nausea/Vomiting	
Vision Loss			Abdominal Pain	
			Diarrhea	
Head and Neck			Constipation	
Headache			Blood in stool	
Sore Throat				
Ear Pain			**Genitourinary**	
Nasal Discharge			Pain with urination	
Hearing loss			Hesitancy	
Ear Ringing			Blood in urine	
			Incontinence	
Skin				
Rash			**Neurologic**	
Eczema			Numbness/tingling	
			Weakness	
Musculoskeletal				
Joint pain			**Psychological**	
Joint swelling			Depressed	
Joint stiffness			Anxiety	

Patient Name: ______________________________________**Date of Birth:**________________

Santa Barbara Doctor

Please list past **medical** history including dates:

____
____
____
____

Please list past **surgical** history or **procedures** including dates:

____
____
____
____

Please list all pertinent family medical history including type of relative (e.g. Aunt)

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

Relationship status:
Married/Partner ____ Single ____ Divorced ____ Widowed ____

Are you currently sexually active?
Preferred sexual partner: Men ____ Women ____ Both ____Never sexually active ____

Do you smoke? If so, how much and for how long: ______________________

Do you drink alcohol? If so, how much: ______________________

Vaccines: If received, please give date:
Tetanus/tdap________________ Influenza ________________ Hepatitis A / B ______________________
Pneumonia _________________ Shingles _________________ Gardasil ___________________________

Women's Health

Last Menstrual Cycle: ____________________ Are you on birth control /type? ______________________

Number of Pregnancies: _________________ Number of births: _________________________
Pap Test:__________________Breast Exam/Mammogram: ____________________________

Please describe your diet and physical activity/exercise:

____

Preventative Health

Please include dates:

Colonoscopy: __________________________ Bone Density Test: ________________________________

Most recent set of lab work:_____________

Patient Name:_____________________________________**Date of Birth:**_________________________