

**Karina Garcia, MD**  
*Internal Medicine*  
229 W. Pueblo St.  
Santa Barbara, CA 93105  
**Phone: (805) 898-0500 Fax: (805) 617-0904**

**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.*

**Select Reminder Preference:**      Phone      Email      Mail      Fax

**Select Language:**      Dutch      English      French      Spanish      Japanese

**Select Race:**      American Indian      Asian      African American      White      Hawaiian or Pacific Islander

**Select 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:** \_\_\_\_\_

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

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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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:** \_\_\_\_\_