

# **Santa Barbara Doctor**

**Barbara A. Hrach, M.D., FACP**

**Virginia Pagenkopf F.N.P**

*Internal Medicine*

229 W. Pueblo St. Santa Barbara, CA 93105

(805) 898-0500

[www.santabarbaradoctor.net](http://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

<b>Name</b>	<b>Dose</b>	<b>Times taken Daily</b>

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

# Santa Barbara Doctor

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

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

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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:

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**Preventative Health**

Please include dates:

Colonoscopy: \_\_\_\_\_ Bone Density Test: \_\_\_\_\_

Most recent set of lab work: \_\_\_\_\_

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