SANTA BARBARA DOCTOR
**Barbara A. Hrach, M.D., FACP**
**Vicky Diaz Pagenkopf, FNP**
229 W. Pueblo St. Santa Barbara, CA 93105
Phone: (805) 898-0500
Fax: (805) 898-0501
www.santabarbaradoctor.net

CLEAR ENTIRE FORM

## *GENERAL INFORMATION (PLEASE PRINT CLEARLY)*

**Personal Information:**

| | | |
|---|---|---|
| Full Name: | | Date of Birth: |
| Address: | | Gender: ☐ MALE ☐ FEMALE |
| City: | State: | Zip Code: |
| Home Phone: | Cell Phone: | Work Phone: |
| Is it okay to leave a private message on your telephone(s)? ☐ YES ☐ NO | | |
| Email: | Social Security #: | |

How did you hear about us? _____

**Employment Information:**

| | |
|---|---|
| Place of Employment: | Work Phone: |
| May we contact you at work? ☐ YES ☐ NO | |

**Emergency Contact Information:**

| | | |
|---|---|---|
| Full Name: | Relationship to Patient: | |
| Address: | | |
| City: | State: | Zip Code: |

**Language Information:**

Language Preference: ☐ Dutch ☐ English ☐ French ☐ Spanish ☐ Japanese

**Demographic Information:**

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

***Appointment Reminder Preference***: ☐ Telephone ☐ Email ☐ Postal Mail ☐ FAX #:

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***Patient Health Questionnaire: (PLEASE PRINT CLEARLY)***

Primary reason for today's visit: _____

_____

Medication Allergies: _____

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

| Name | Dosage | Times taken daily |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Pharmacy Information:**

| Pharmacy Name: | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip Code: |

Patient Name: _____ Date: _____

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***Review of Systems: (PLEASE PRINT CLEARLY)***

Please check-mark the YES columns if you have any of the following:

| **General** | ***Yes*** |
|---|---|
| Weight gain | ☐ |
| Weight loss | ☐ |
| Memory loss | ☐ |
| Fatigue | ☐ |
| Fever/chills | ☐ |
| Night sweats | ☐ |
| Change in appetite | ☐ |

| **Eyes** | |
|---|---|
| Glasses | ☐ |
| Contact Lenses | ☐ |
| Blurriness | ☐ |
| Tearing | ☐ |
| Itching | ☐ |
| Vision Loss | ☐ |

| **Head and Neck** | ***Yes*** |
|---|---|
| Headache | ☐ |
| Sore Throat | ☐ |
| Ear Pain | ☐ |
| Nasal Discharge | ☐ |
| Hearing loss | ☐ |
| Ear Ringing | ☐ |

| **Skin** | ***Yes*** |
|---|---|
| Rash | ☐ |
| Eczema | ☐ |

| **Musculoskeletal** | ***Yes*** |
|---|---|
| Joint pain | ☐ |
| Joint swelling | ☐ |
| Joint stiffness | ☐ |

| **Respiratory** | ***Yes*** |
|---|---|
| Shortness of breath | ☐ |
| Cough | ☐ |
| Wheezing | ☐ |
| Sputum | ☐ |

| **Cardiac** | ***Yes*** |
|---|---|
| Chest pain | ☐ |
| Palpitations | ☐ |
| Murmur | ☐ |
| Leg swelling | ☐ |

| **Gastrointestinal** | ***Yes*** |
|---|---|
| Heartburn | ☐ |
| Nausea/Vomiting | ☐ |
| Abdominal Pain | ☐ |
| Diarrhea | ☐ |
| Constipation | ☐ |
| Blood in stool | ☐ |

| **Genitourinary** | ***Yes*** |
|---|---|
| Pain with urination | ☐ |
| Hesitancy | ☐ |
| Blood in urine | ☐ |
| Incontinence | ☐ |

| **Neurologic** | ***Yes*** |
|---|---|
| Numbness/tingling | ☐ |
| Weakness | ☐ |

| **Psychological** | ***Yes*** |
|---|---|
| Depressed | ☐ |
| Anxiety | ☐ |

Patient Name: _____ Date: _____

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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. _____

| |
|---|
| Are you currently sexually active? ☐ YES ☐ NO |
| Preferred sexual partner: ☐ MEN ☐ WOMEN ☐ BOTH ☐ NEVER SEXUALLY ACTIVE |

| | |
|---|---|
| Do you smoke? ☐ NOW ☐ PAST ☐ NEVER | If so, how much and for how long: |
| Do you drink alcohol? ☐ NOW ☐ PAST ☐ NEVER | If so, how much: |

**Vaccines:** If received, please give date:

| | | |
|---|---|---|
| Tetanus/tdap: | Influenza: | Hepatitis A/B: |
| Pneumonia: | Shingles: | Gardasil: |

Patient Name: _____ Date: _____

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***WOMEN'S HEALTH INFORMATION (PLEASE PRINT CLEARLY)***

| | |
|---|---|
| Last Menstrual Cycle: | Are you on birth control/type: |
| Number of Pregnancies: | Number of births: |
| Last Pap Test: | Last Breast Exam/Mammogram: |

Please describe your diet and physical activity/exercise:

_____

_____

_____

***PREVENTATIVE HEALTH INFORMATION (PLEASE INCLUDE DATES)***

Colonoscopy: _____ Bone Density Test: _____

Most recent set of lab work: _____

Patient Name: _____ Date: _____