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:	
Home Phone:		
Cell Phone:	Work Phone:	

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: _____