



DENNIS SLAVIN, M.D.

**PATIENT INFORMATION**

Last Name	First Name	Middle Initial	Nickname/AKA	
Date of Birth	Social Security Number		Gender	Male Female
Home Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone Cell Pager Fax		
Email Address				

**PHYSICIAN REFERRAL INFORMATION**

Primary Care Physician	Referring Physician
How did you hear about us?	

**RESPONSIBLE PARTY (GUARANTOR) INFORMATION**

Relationship to Patient	(If self, skip to Emergency Contact) ___ Spouse ___ Parent ___ Other			
Last Name	First Name	Middle Initial		
Date of Birth	Social Security Number			
Home Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone Cell Pager Fax		

**EMERGENCY CONTACT INFORMATION**

Last Name	First Name	Relationship to Patient		
Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone Cell Pager Fax		

**INSURANCE INFORMATION**

Primary Insurance	ID Number	Group Number	Telephone Number
Secondary Insurance	ID Number	Group Number	Telephone Number
Insured Member	Social Security Number	Date of Birth	ID Number



### PAST MEDICAL HISTORY

NAME: \_\_\_\_\_

Date: \_\_\_\_\_

**DO YOU HAVE A HISTORY OF?**

- |                                   |   |  |                                      |                                     |
|-----------------------------------|---|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung        | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney      | <input type="checkbox"/> Arthritis  |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> GI Problems   | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Other      |

**FEMALE PATIENTS ONLY:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Regular Medications   | <input type="checkbox"/> Hysterectomy   | <input type="checkbox"/> Bilateral Hysterectomy |
| <input type="checkbox"/> Last Menstrual Period | <input type="checkbox"/> Tubal Ligation |   |

**CURRENT MEDICATIONS YOU ARE TAKING**

- |          |           |
|----------|-----------|
| 1) _____ | 6) _____  |
| 2) _____ | 7) _____  |
| 3) _____ | 8) _____  |
| 4) _____ | 9) _____  |
| 5) _____ | 10) _____ |

**PAST SURGICAL HISTORY**

_____	_____
_____	_____
_____	_____

**PERSONAL/SOCIAL HISTORY**

Are both your parents still living?  YES  NO Cause of Death? Mother \_\_\_\_\_ Father \_\_\_\_\_

Do you drink alcoholic beverages?  YES  NO

Social <1 drink/day \_\_\_\_\_ drinks per day

How much smoking daily? \_\_\_\_\_ packs per day

For how long? \_\_\_\_\_ years If quit, when? \_\_\_\_\_

Do you use any street drugs (like cocaine/marijuana)?  YES  NO

What and when last used?

Marital Status: Single Married Divorced Widowed

With whom do you live? \_\_\_\_\_

Are you currently working?  YES  NO If not, when worked last? \_\_\_\_\_

What is/was your occupation? \_\_\_\_\_

Do you attend Adult Activity Centers?  YES  NO