OSCAR J. CERDA, M.D., P.A.

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NEW PATIENT INFORMATION

DEMOGRAPHIC INFORMATION: **DATE:**

Reason for your visit today:			
Patient name:	DOB:	Age:	M / F
Address:	City/St/Zip:		
Hm Ph:	Alt. Ph.:		
SSN:	Marital Status:	spouse name:	
Employer:	Occupation:		
Driver's Lic Number:	State:		
Resp. party:	Address:		
If minor, Parent or legal guardian's Name and telephone number:			
Who referred you to Dr. Cerda: yellow pages, friend, employer, other:			

EMERGENCY INFORMATION:

Name of contact:	Phone number:
Address:	Relationship:

INSURANCE INFORMATION:

Primary Insurance:	Policy#:	Grp#:
Policy holder SSN:	Policy holder DOB:	
Secondary Insurance:	Policy#:	Grp#:
Policy holder SSN:	Policy holder DOB:	

PATIENT DATA FORM

Name:_____ DOB:_____

Do you have or have you ever had any of the following: (please check if applicable)

__ Deafness / Decreased Hearing
__ Heart Problems
__ Heart Attack
__ High Blood Pressure
__ Blood Transfusion
__ Anemia
__ Bleeding Disorder
__ High Cholesterol
__ Lung Problems
__ Asthma
__ Pneumonia
__ Rheumatic Fever
__ Scarlet Fever
__ Tuberculosis
__ Allergies
__ Epilepsy / Seizures
__ Mental Illness
__ Nervous Breakdown
__ Mental Retardation
__ Cancer
__ Stroke
__ Blindness
__ Glaucoma
__ Sinus Infection
__ Urine Infection
__ Kidney Disease
__ Kidney Stone
__ Thyroid Problems
__ Venereal Disease
__ Diabetes Mellitus
__ Hemorrhoids
__ Stomach / Bowel Problems
__ Ulcers
__ Migraines
__ Arthritis
__ Hepatitis
__ Liver Problems
__ Gout
__ Broken Bones
__ Joint Dislocation
__ Birth Defects
__ Amputations
__ HIV

CURRENT MEDICATIONS	STRENGTH	DIRECTIONS	REASON

DATES OF LAST IMMUNIZATIONS:

PNUEMONIA	
TETANUS	
FLU	
OTHER	

PATIENT NAME:_____DOB:_____

CURRENT SYMPTOMS: please check all that apply

__ Headaches	__ Hoarseness	__ Bowel problems
__ Vision Problems	__ Throat problems	__ Bladder problems
__ Nasal Congestion	__ Swallowing problems	__ Sexual difficulties
__ Runny nose	__ Dizziness	__ Weakness
__ Ear problems	__ Breathing problems	__ Numbness
__ Chest pain	__ Stomach problems	__ Weight changes

ALLERGIES TO MEDICINES

Medicine	Reaction

PAST SURGICAL HISTORY

Operations (include biopsy)	Year	Surgeon	Reason for Surgery

HOSPITALIZATIONS (Non-Surgical)

Hospital	Year	Reason for Admission

FAMILY HISTORY

Diabetes:	Father	Mother	Brother	Sister	Child
High Blood Pressure:	Father	Mother	Brother	Sister	Child
Cancer/Type:	Father	Mother	Brother	Sister	Child
Heart Disease:	Father	Mother	Brother	Sister	Child
Glaucoma:	Father	Mother	Brother	Sister	Child
Anemia:	Father	Mother	Brother	Sister	Child
Osteoporosis:	Father	Mother	Brother	Sister	Child

Other:

PATIENT'S NAME:_____DOB:_____

SOCIAL AND PERSONAL HISTORY

Marital Status: Single Married Widowed Divorced Separated

Do you currently smoke? Yes / No If so, how many packs per day? _____

How many years have you smoked? _____

Did you quit smoking? _____ When?_____ How many years did you smoke?_____

Do you currently drink alcohol? Yes / No How much?_____

Have you quit drinking? _____ When? _____

Do you currently use illegal drugs? Yes / No Have you ever used illegal drugs? Yes / No

If so, which ones? _____

Are you sexually active? Yes / No Heterosexual _____ Homosexual _____

Do you engage in risky sexual behaviors? Yes / No

PERIODIC EXAMINATIONS

Please check exam and state when.

__ Pap Smear _____ __ Mammogram _____

__ Rectal Exam _____ __ Chest X-ray _____

__ EKG _____ __ Test for blood in stool _____

__ Blood Work _____ __ Colonoscopy Exam _____

FOR WOMEN ONLY:

Last menstrual period:_____ method of birth control _____

Number of preganancies:_____ Live births _____ Miscarriages _____ Abortions ____

Age of Menopause:_____ Natural or Surgical