Gulf Coast Regional Medical Care
4121 US 98
Panama City, FL 32401
Phone (850)872-9701 Fax (850)872-0567

PATIENT INFORMATION **Date _____**

Prefix: _____Mr. _____Mrs. _____ Ms. _____ Dr. Suffix: _____ Sr. _____ Jr. _____II _____ III _____ IV

Name_____ Soc. Sec. #_____
Last First MI

Address_____

City_____ State_____ Zip_____ Home Phone _____

Cell Phone _____Email Address _____ Contact preference: _____

Marital Status: _____Married _____ Divorced _____ Single _____ Widowed _____ Legally Separated

Employment status: _____ Full time _____ Part Time _____ Not employed _____ self-employed _____ retired _____active military

Student status: _____ Full time student _____ Part time student _____ Not a student

Sex: M_____F_____Age_____ Birthdate_____ Race _____ Ethnicity _____

Primary language spoken _____ Do you have a living will? _____ Yes _____ No

In case of emergency who should be notified? _____ Relationship_____ Phone _____

Are you a new patient? _____ Yes _____ No If so, How did you hear about us? Please check one:

_____Online/Website _____ Family/Friend _____Clinic Sign _____Digital Sign

_____Billboard (if so, where was the billboard located?_____

_____Physician (if so, which physician referred you?) _____

_____Hospital (if so, which hospital referred you?) _____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____
Last First MI

Relationship to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (if different from patient's) _____Phone_____

City_____ State_____ Zip_____

PRIMARY INSURANCE

Insurance Company_____ Policy #_____ Group#_____

Policy Holder's Name_____ Relation to Patient_____ Birthdate_____ SS#_____

Policy Holder Employed by _____ Business Phone_____

ADDITIONAL INSURANCE

Insurance Company_____ Policy #_____ Group#_____

Policy Holder's Name_____ Relation to Patient_____ Birthdate_____ SS#_____

ASSIGNMENT AND RELEASE

I the undersigned and certify that I (or my dependent) have insurance coverage and assign directly to Seawind Medical Clinic, insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party (print name) Signature Date

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Patient Name _____ Date_____

Who is your Primary Care Physician? _____

What doctors have you seen in the past 3 years (list name – specialty)?

_____
_____
_____

Medical History: Please mark next to any medical conditions or symptoms that you have or have had in the past (use the space provided for details: how long, etc.):

HEENT/Pulmonary

☐ **No** ☐ **Yes** Glasses/Contacts: _____
☐ **No** ☐ **Yes** Vision Changes: _____
☐ **No** ☐ **Yes** Glaucoma or cataracts: _____
☐ **No** ☐ **Yes** Cough: _____
☐ **No** ☐ **Yes** Coughing up blood: _____
☐ **No** ☐ **Yes** Persistent Hoarseness: _____
☐ **No** ☐ **Yes** Shortness of breath: _____
☐ **No** ☐ **Yes** Asthma: _____
☐ **No** ☐ **Yes** Tuberculosis: _____
☐ **No** ☐ **Yes** COPD/lung disease: _____
☐ **No** ☐ **Yes** Trouble swallowing:_____

Cardiac

☐ **No** ☐ **Yes** Chest pain: _____
☐ **No** ☐ **Yes** Leg swelling:_____
☐ **No** ☐ **Yes** Palpitations:_____ _____
☐ **No** ☐ **Yes** Heart Murmur _____
☐ **No** ☐ **Yes** Irregular heart rhythm: _____
☐ **No** ☐ **Yes** High blood pressure: _____
☐ **No** ☐ **Yes** High Cholesterol: _____
☐ **No** ☐ **Yes** Heart disease: _____
☐ **No** ☐ **Yes** Heart attack: _____

Neurological (if yes, please explain below):

☐ **No** ☐ **Yes** Dizziness: _____
☐ **No** ☐ **Yes** Memory changes: _____
☐ **No** ☐ **Yes** Seizures: _____
☐ **No** ☐ **Yes** Confusion: _____
☐ **No** ☐ **Yes** Chronic Headaches or Migraines: (if yes, frequency) _____
☐ **No** ☐ **Yes** Stroke: _____

Endocrine/Rheumatology:

☐ **No** ☐ **Yes** Diabetes/sugar: _____
If yes: (controlled with) ____A. Diet ____B. Insulin ____C. Oral Meds
☐ **No** ☐ **Yes** Thyroid Disease: _____
☐ **No** ☐ **Yes** Heat or cold tolerance: _____
☐ **No** ☐ **Yes** Low testosterone: _____

☐ **No** ☐ **Yes** Osteoporosis/osteopenia: _____
☐ **No** ☐ **Yes** Joint pain/swelling/arthritis_____
☐ **No** ☐ **Yes** Gout: _____
☐ **No** ☐ **Yes** Back pain: _____
☐ **No** ☐ **Yes** Hormone Replacement Therapy: _____

Gastroenterology:
☐ **No** ☐ **Yes** GERD/acid reflux: _____
☐ **No** ☐ **Yes** Abdominal pain or ulcers: _____
☐ **No** ☐ **Yes** Blood in stool: _____
☐ **No** ☐ **Yes** Frequent diarrhea: _____
☐ **No** ☐ **Yes** Frequent constipation: _____
☐ **No** ☐ **Yes** Frequent vomiting: _____
☐ **No** ☐ **Yes** Abnormal appetite: _____
☐ **No** ☐ **Yes** Liver disease/hepatitis: _____
☐ **No** ☐ **Yes** Change in appetite: _____
☐ **No** ☐ **Yes** Weight loss or gain: _____

Urology/Nephrology
☐ **No** ☐ **Yes** Urinary frequency, hesitancy, urgency, incontinence (Circle ones that apply)
☐ **No** ☐ **Yes** Blood in urine: _____
☐ **No** ☐ **Yes** Weak urinary system: _____
☐ **No** ☐ **Yes** Kidney stones or kidney dysfunction: _____
☐ **No** ☐ **Yes** Urinary tract, Kidney infections, Kidney stones (Circle ones that apply)
☐ **No** ☐ **Yes** BPH (enlarged prostate) or Trouble urinating: _____
☐ **No** ☐ **Yes** Chronic renal insufficiency: _____
☐ **No** ☐ **Yes** Dialysis _____

Psychiatric:
☐ **No** ☐ **Yes** Anxiety: _____
☐ **No** ☐ **Yes** Depression: _____
☐ **No** ☐ **Yes** ADD/ADHD: _____
☐ **No** ☐ **Yes** Mental Illness: _____

Other:
☐ **No** ☐ **Yes** Fever: _____
☐ **No** ☐ **Yes** Anemia: _____
☐ **No** ☐ **Yes** Bleeding disorder: _____
☐ **No** ☐ **Yes** Measles: _____
☐ **No** ☐ **Yes** Mumps: _____
☐ **No** ☐ **Yes** German Measles: _____
☐ **No** ☐ **Yes** Scarlet fever: _____
☐ **No** ☐ **Yes** Chicken pox: _____
☐ **No** ☐ **Yes** Polio: _____
☐ **No** ☐ **Yes** Meningitis: _____
☐ **No** ☐ **Yes** HIV or AIDS: _____
☐ **No** ☐ **Yes** Syphilis: _____
☐ **No** ☐ **Yes** Lyme disease: _____
☐ **No** ☐ **Yes** Rash: _____

Miscellaneous
☐ **No** ☐ **Yes** Thyroid Disorder: (if yes, what type) _____
☐ **No** ☐ **Yes** Cancer: (Please specify which type) _____
☐ **No** ☐ **Yes** Bleeding disorder: (if yes please explain) _____

□ **No** □ **Yes** Blood Clots: (if yes please explain) _____

□ **No** □ **Yes** Could you be pregnant?: (Women only)_____

Preventative Health Maintenance:

Screening	Date	Result
Pap		
Mammogram		
DEXA Scan/Bone density scan		
Colonoscopy		
PSA		
Digital Rectal Exam		
Labs		
Diabetic Eye Exam (if applicable)		
EKG (for Blood Pressure, Diabetes or Coronary Artery Disease)		
Monthly Self Breast or Testicular Exams		
Tetanus Vaccine		
Pneumonia Vaccine: prevnar or pneumovax (circle one)		
Shingles Vaccine		
Flu Vaccine		
Hemoccult: test for blood in stool		

Family History : (check box and indicate which family member and if alive of deceased)

	Grandparents M- Maternal P- Paternal	**Parents** M-mother F- Father	**Siblings**
DVT/blood clot			
Mental Illness			
Kidney Disease			
Heart Disease			
Stroke			
Autoimmune disease			
Diabetes			
High Cholesterol			
High blood pressure			
Epilepsy			
Migraine			
Tuberculosis			
Colon Cancer			
Breast Cancer			
Lung Cancer			
Heart attack			
Cancer: what type			
Asthma			

Surgical History:

Please list any surgery you have had in the past and the approximate date of your surgery.

Surgery	Date	Physician	Facility

Social History:

Do you presently or have a history of tobacco use? ____ Yes _____ No
If so packs per day? _____ Years used? _____ When did you quit? _____

Do you currently or have a history of alcohol use? _____ Yes _____ No
If so, type? _____ Amount? _____ Frequency? _____

Do you currently or have a history of drug use? _____ Yes _____ No
If so, type? _____ Frequency? _____ When did you quit? _____

Please mark your highest level of education:
□ Did ***not*** **c**omplete high school
□ Completed high school
□ Some college
□ Bachelor's degree
□ Advanced degree

Current Medications: List medications and dose that you take.
Please list prescription as well as Over-The-Counter (OTC) medications, vitamins, supplements and herbs.

Name of current Medication	How much? (dose)	How often? (frequency)	For treatment of:	Prescribed by:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

What pharmacy do you want your prescriptions sent to?
_____

Address _____ telephone number _____

Medication Allergies: □ I do not have any known allergies to medication
□ Codeine □ Penicillin □ Sulfa □ Other _____

What is your reaction to medication allergies? Ie. Rash, vomiting, etc _____

Non-Medication Allergies: □ I do not have any known allergies
□ latex □ IVP dye □ eggs □ environmental Other _____

CONSENT FOR TREATMENT

I consent to treatment ordered and performed by these physicians and/or their practitioners under the physician's direction within this office. I understand that treatment will be explained fully to me before the treatment is performed. This consent shall be in effect until I notify Seawind Medical Clinic of its cancellation.

_____ _____
Patient's or Authorized Person's Signature Date