• Convenient
• Compassionate
• Comprehensive

CASTLE PINES
URGENT CARE / FAMILY PRACTICE
A Division of OnPoint Medical Group

Castle Pines Family Practice

What brings you in today? _____

_____

Patient Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (Apartment #)

_____
(City) State Zip

Date of Birth __/__/__ Sex: _____ Marital Status: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Who is your Primary Care Provider? _____

Where can we best reach you if we have messages to return, lab results or questions?

#: _____

List names of all persons to whom we may communicate results: _____

_____

Is it OK to leave results for you at the number above? ☐ Yes | ☐ No

Emergency Contact Info: _____ Phone: _____

Relation to Patient: _____

Employer: _____ Occupation: _____

Work Phone: _____ Extension: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Co-Pay Amount: _____

Group (account) # _____ ID (Member) # _____

Primary Insured Name: _____ SS# _____

DOB: __/__/__ Relationship: _____ Sex: _____

Address if Different from Patient: _____

Employer: _____ Work Phone: _____

Secondary Insurance: _____ Co-Pay Amount: _____

Group (account) # _____ ID (Member) # _____

Primary Insured Name: _____ SS# _____

DOB: __/__/__ Relationship: _____ Sex: _____

Address if Different from Patient: _____

Employer: _____ Work Phone: _____

Pharmacy	Address/Cross Street	Phone Number	Preferred
			☐
			☐

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, M.I)*:	☐ M ☐ F	**DOB:**
Marital Status: ☐ Single ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed		
Previous or Referring Provider:		**Date of last physical exam:**

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name on the Drug	Strength	mg / other Measurement	Frequency Taken	Diagnosis

Allergies to medications

Name the Drug	Reaction You Had

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations & Dates:	☐ Tetanus	☐ Pneumonia - Prevnar 13	☐ Pneumonia - Pneumovax 23
	☐ Hepatitis A	☐ Chickenpox	
	☐ Hepatitis B	☐ Influenza	
	☐ MMR *(Measles, Mumps, Rubella)*	☐ Shingles	

PAST MEDICAL HISTORY (Please check all diagnoses that apply to you and add notes as needed)

☐ None	☐ COPD / Emphysema	☐ Head Injury / Concussion	☐ Oxygen use
☐ AIDS	☐ CVA / Stroke	☐ Hearing Loss	☐ Peripheral Artery Disease
☐ Anemia	☐ Diabetes - Type:_____	☐ Heart Disease	☐ Pneumonia
☐ Angina (Heart Pain)	☐ Dialysis – Type:_____	☐ Heart Failure	☐ Restless Leg Syndrome
☐ Arrhythmia / Palpitations	☐ Disabilities – Type:_____	☐ Hepatitis – Type:	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Diverticulitis	☐ HIV	☐ Sciatica
☐ Asthma	☐ Ear Infection, recurrent	☐ High Cholesterol	☐ Scoliosis
☐ Atrial Fibrillation	☐ Environmental Allergies	☐ High Blood Pressure	☐ Seasonal Allergies
☐ Bleeding disorder	☐ Food Allergies	☐ Irritable Bowel Syndrome	☐ Seizures
☐ Blood Clot	☐ Fibromyalgia	☐ Kidney Stone	☐ Sinusitis, recurrent
☐ Blood Transfusion	☐ Genetic Condition	☐ Long-term Steroid Use	☐ Sleep Apnea
☐ Bone Loss	☐ Congenital Condition	☐ Lupus	☐ Thyroid Disorder
☐ Cataracts	☐ GERD (Heartburn)	☐ Macular Degeneration	☐ Tuberculosis
☐ Chronic Fatigue	☐ GI Bleed	☐ MI (Heart Attack) – Date:	☐ UTI (bladder infection)
☐ Chronic Kidney Disorder	☐ Glaucoma	☐ Motor Vehicle Accident	☐ Vertigo
	☐ Gunshot Wound		

Castle Pines Family Practice

PREVENTATIVE HEALTH SCREENINGS (Please list the date of last testing and results/ additional notes)		
Test	Date	Result/Notes
Bone Density (DEXA)		
Cervical Cancer Screening (Pap Testing)		
Colon Cancer Screening | Type: ☐ Colonoscopy ☐ FIT ☐ FOBT ☐ Sigmoidoscopy ☐ Cologuard		
Mammography		
Lung Cancer Screening		
AAA Screening		
Hepatitis C Screening		

SURGICAL HISTORY (Please list surgeries and add any notes as needed)			
Year	Surgery/Procedure	Hospital	Comments or Complications

Have You Ever Had a Blood Transfusion? ☐ Yes | ☐ No

HEALTH HABITS AND PERSONAL SAFTEY

ALL QUESTIONS CONTAINED IN THIS QUESTIONAIRRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise:	☐ Sedentary (No Exercise)				
	☐ Mld Exercise (climb stairs, walk 3 blocks, golf)				
	☐ Occasional Vigorous Exercise (work or recreation, less than 4x/week for 30 min.)				
	☐ Regular Vigorous Exercise (work or recreation 4x/week for 30 minutes.)				
Diet:	Are you dieting?				☐ Yes | ☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes | ☐ No
	# of meals you eat in an average day?				
	Rank Salt Intake	☐ Hi	☐ Med		☐ Low
	Rank Fat Intake	☐ Hi	☐ Med		☐ Low
Caffeine:	☐ None	☐ Coffee	☐ Tea		☐ Cola
	# of cups/cans per day?				
Alcohol:	Do you drink Alcohol?				☐ Yes | ☐ No
	If yes, what kind?				
	How Many Drinks Per Week?				
	Are you concerned about the amount you drink?				☐ Yes | ☐ No
	Have you ever considered stopping?				☐ Yes | ☐ No
	Have you ever experienced blackouts?				☐ Yes | ☐ No
	Are you prone to "binge" drinking?				☐ Yes | ☐ No
	Do you drive after drinking?				☐ Yes | ☐ No
Tobacco	Do you use tobacco?				☐ Yes | ☐ No
	☐ Cigarettes – pks./day	☐ Chew – #/day	☐ Pipe – #/day	☐ Cigars – #/day	
	☐ # of Years	☐ Or year quit			
Drugs:	Do you currently use recreational or street drugs?				☐ Yes | ☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes | ☐ No
Sex	Are you sexually active?	☐ Never	☐ Not Currently	☐ Yes	☐ Men ☐ Women
	If yes, are you trying for a pregnancy?				☐ Yes | ☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				

Name: _____ Date: _____

	Any discomfort with intercourse?	☐ Yes | ☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes | ☐ No
Personal Safety	Do you live alone?	☐ Yes | ☐ No
	Do you have frequent falls?	☐ Yes | ☐ No
	Do you have vision or hearing loss?	☐ Yes | ☐ No
	Do you have an advance directive or living will?	☐ Yes | ☐ No
	Would you like information on the preparation of these?	☐ Yes | ☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes | ☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling/s	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Grandmother *Maternal*		
	☐ M ☐ F		Grandfather *Maternal*		
	☐ M ☐ F		Grandmother *Paternal*		
	☐ M ☐ F		Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes | ☐ No
Do you feel depressed?	☐ Yes | ☐ No
Do you panic when stressed?	☐ Yes | ☐ No
Do you have problems with eating or your appetite?	☐ Yes | ☐ No
Do you cry frequently?	☐ Yes | ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes | ☐ No
Have you ever attempted suicide?	☐ Yes | ☐ No
Do you have trouble sleeping?	☐ Yes | ☐ No
Have you ever been to a counselor?	☐ Yes | ☐ No
If you could change two things about your health/wellbeing, please explain what those things would be:	

Additional Past Medical History:

Name: _____ Date: _____

OTHER PROBLEMS

Please check any symptoms you've experienced over the LAST ONE TO TWO WEEKS:

General/ Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Diaphoresis (Sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Irritability
- ☐ Unexpected Weight Change

Ear, Nose & Throat
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia (Sensitivity to Light)
- ☐ Visual Disturbance (Blurred Vision)

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Airway Obstruction)
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations (Irregular Heart Beat)

Gastrointestinal
- ☐ Abdominal Distention (Bloating)
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Abnormal Thirst)
- ☐ Polyphagia (Abnormal Hunger)
- ☐ Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Swelling
- ☐ Myalgias (Muscle Pain)
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Pallor (Paleness)
- ☐ Rash
- ☐ Wounds

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurologic
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headache(s)
- ☐ Light Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Loss of Consciousness)
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy (Swollen Glands)
- ☐ Bruising Tendency
- ☐ Bleeding Tendency

Behavioral
- ☐ Agitation
- ☐ Behavioral Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Mood Changes)
- ☐ Hallucinations
- ☐ Hyperactive Nervousness
- ☐ Anxiety
- ☐ Self Injury
- ☐ Sleep Disturbance
- ☐ Suicidal

Name: _____ Date: _____

OTHER CONCERNS
Please use the space below to share any other concerns.

Billing Procedure

I authorize the release of any information necessary to process claims. I request payment of benefits to Castle Pines Family Practice. I understand I am financially responsible for any charges not covered by this authorization. I agree to pay for charges that are not covered by my insurance coverage.

Signature _____ Date: __/__/__ Relationship to Patient _____

Consent for Care of Minors

My son/daughter is a minor (less than 18 years of age primarily supported by a parent or guardian), I understand and agree that he/she may be evaluated and/or treated by Castle Pines Family Practice and staff if I am not present to give consent. This may include but not necessarily be limited to physical exam, blood and urine tests, injections, and the prescription medications in my absence.

Signature _____ Date: __/__/__ Relationship to Patient _____