# Daniel J. D'Arco, MD 111 S. Centre St. Pottsville, PA 17901

Account #_____ Date:_____

## PATIENT INFORMATION AND HISTORY

Name:_____ Date of Birth_____ Age: _____
(Last) (First) (MI)

Address: _____ Social Security # _____

_____ Family Doctor:_____

Employer: _____ Occupation: _____

Spouse/guardian/caregiver Name: _____ Relationship:_____

_____ _____ _____ _____
(HomePhone) (Work Phone) (Emergency Phone) (Name of emergency contact)

Cell Phone _____

## CURRENT PROBLEM

What are you being seen for today? _____ How long have you had this? _____

Accident or Work related? _____ Who sent you to us?_____ Did you have Xrays? _____

Where? _____

**Do you have any medication or Latex allergies? _____**

**_____**

**Type of reaction: _____**

**PHARMACY NAME:**_____ **NUMBER:**_____

## MEDICAL HISTORY

***Please circle any conditions you have and /or had and explain treatment***

| | | | |
|---|---|---|---|
| Anemia | Phlebitis/Blood Clots | Asthma | Cancer |
| Chronic Back Pain | Diabetes Mellitus | Emphysema | Gout |
| Heart Disease | Hepatitis/Jaundice | Hypertension | Kidney Disease |
| Myocardial Infarction | Peptic Ulcer | Peripheral Vasc Disease | Thyroid Disease |
| Pulmonary Embolism | Rheumatoid Arthritis | Rheumatic Heart Disease | |

**Name:** _____ **Date of Birth:** _____

## HOSPITALIZATIONS: LIST AND INDICATE APPROXIMATE YEAR

1._____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

## SOCIAL HISTORY

Do you smoke? (CIRCLE ONE) NEVER FORMER CURRENT Number per day? ____

Do you drink alcohol? _____Describe your usage of alcohol or drugs: _____

## FAMILY HISTORY: CHECK ALL THAT APPLY

| | Stroke | Heart Attack | Diabetes | Cancer | Arthritis | High BP | TB | Living | Deceased |
|---|---|---|---|---|---|---|---|---|---|
| Father | □ | □ | □ | □ | □ | □ | □ | □ | □ |
| Mother | □ | □ | □ | □ | □ | □ | □ | □ | □ |
| Brother | □ | □ | □ | □ | □ | □ | □ | □ | □ |
| Sister | □ | □ | □ | □ | □ | □ | □ | □ | □ |
| Grandmother | □ | □ | □ | □ | □ | □ | □ | □ | □ |
| Grandfather | □ | □ | □ | □ | □ | □ | □ | □ | □ |

## REVIEW OF SYMPTOMS

PLEASE CIRCLE ANY OF THE CONDITIONS YOU HAVE CURRENTLY OR RECENTLY EXPERIENCED

| | | | |
|---|---|---|---|
| Abdominal pain | Anxiety/depression | Bleeding/bruising | Chest pain |
| Cold Intolerance | Frequent lung infections | Headaches | Leg Swelling |
| Nausea | Night Cramps | Numbness/tingling | Sore throat |
| Weakness | Nosebleeds | Rashes | Ringing in the ears |
| Shortness of breath | Seizures | Wheezing | |

## DEMOGRAPHIC INFORMATION FOR ELECTRONIC HEALTH RECORD

**Patient Name _____,** **Todays Date:_____**

**Date of Birth_____**

In order to ensure Meaningful Use Compliance in using our EHR, the following information is needed.

**Contact Information:**

Email Address: _____ Mobile Phone: _____

( ) I do not have an email address ( ) I do not have a mobile phone number

Are you interested in our Patient Portal? Yes No
If yes please provide email address above.

Patient/Guardian Approves the following:
( ) Send mobile text notifications ( ) Send voice notifications

Work Phone: _____ Work Extension: _____
*If retired (circle) "retired" *If unemployed (circle) "unemployed"

**Demographic Information:**

**Ethnicity *(circle):*** Hispanic or Latino Not Hispanic or Latino Patient declined to specify

**Preferred Language**: (Circle) English or other _____

**Patient's Race**: _____