Seawind Medical Clinic
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