Edgar S. Macias, M.D.
Brenda Berry, M.D.
Jason Sanchez, PA-C

Phone: 559-431-2397
Fax: 559-472-3382

MRN # ________________

Date: __________________

PATIENT INFORMATION

Patient First & Last Name: ____ Marital status: (circle) S M D W

Address: __________________________________ City: ___________________________ State: ______ ZIP: ___________

Preferred Phone Number: (circle) Home: ________________________ Cell: _______________________ Work: see *below*

E-Mail: ____ Would you like to be notified of services or specials? (circle) Y / N

Date of Birth: ____ / ____ / ____ Age: ______ Sex: (circle) M / F Social Security Number: _______- ______- _________

Preferred Language: _________________________

Ethnic Group: (circle) Hispanic or Latino / *Not* Hispanic or Latino /Unknown / Prohibited by State Law / Declined to State

Race: (circle) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Other Race / Prohibited by State Law / Declined to State

Parent / Guardian / Responsible Party: _________________________________ Relationship: ________________________

Who to notify in case of **emergency**? ____ Relationship: _________________

Daytime Phone Number: ________________________ Alternate Phone Number: ________________________

EMPLOYMENT INFORMATION

Employer: ____ Work Phone Number: _________________________

Occupation: ____

INSURANCE INFORMATION

Primary: ____ / Secondary: ____

Responsible (or Insured) Party's Name: _____________________________________ Date of Birth: ____ / ____ / ____

Employer: ______________________ Patient's Relationship to Insured: (circle) Spouse / Child / Other: __________

REFERRAL INFORMATION

How were you referred to our practice? (circle) Physician: ___________________________ / Other: ___________________

If applicable: Physician Address: ________________________________ City: ____________________ State: ______ ZIP: ___________

Primary Care Physician: __________________________________ Phone Number: ________________________

Address: __________________________________ City: ___________________________ State: ______ ZIP: ___________

I hereby authorize the above information is correct.

Patient/Responsible Party Signature: _____________________________________ Date: _______________ Revised 5/15/14

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Medical History Information

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Patient First & Last Name: ____

Current Medical Conditions Check all that apply:

	Anxiety		Depression		Hyperthyroidism
	Arthritis		Diabetes		Hypothyroidism
	Asthma		End Stage Kidney Disease		Leukemia
	Irregular Heartbeat (Atrial Fibrillation)		GERD		Lung Cancer
	Bone Marrow Transplantation		Hearing Loss		Lymphoma
	Benign Prostatic Hypertrophy (BPH)		Hepatitis		Prostate Cancer
	Breast Cancer		Hypertension (High Blood Pressure)		Radiation Treatment
	Colon Cancer		HIV/AIDs		Seizures
	Chronic Obstructive Pulmonary Disease (COPD)		Hyperlipidemia (High Cholesterol)		Stroke
	Coronary Artery Disease				

Primary Care Physician: (first & last) ____________________________ Referring Physician:______________________________

Surgical History Check all that apply:

	Appendix: Removal		Liver: Removal
	Bladder: Removal		Liver: Transplant
	Breast: Biopsy		Liver: Shunt
	Breast: Lump Removal (circle – Both/Left/Right)		Ovaries: Removal due to Endometriosis
	Breast: Removal (circle – Both/Left/Right)		Ovaries: Removal due to Ovarian Cancer
	Colon: Removal due to Colon Cancer Resection		Ovaries: Removal due to Ovarian Cyst
	Colon: Removal due to Diverticulitis		Ovaries: Tubal Ligation
	Colon: Removal due to Inflammatory Bowel Disease		Pancreas: Removal
	Colon: Colostomy		Prostate: Removal after Biopsy
	Gallbladder: Removal		Prostate: Removal due to Prostate Cancer
	Heart: Biological Valve Replacement		Prostate: Transurethral Resection
	Heart: Coronary Artery Bypass (CABG)		Rectum: Abdominoperineal Resection
	Heart: Transplant		Rectum: Low Anterior Resection
	Hip Replacement (circle – Both/Left/Right)		Spleen: Removal
	Knee Replacement (circle – Both/Left/Right)		Testicles: Removal
	Kidney: Biopsy		Uterus: Removal due to Fibroids
	Kidney: Kidney Stone Removal		Uterus: Removal due to Uterine Cancer
	Kidney: Transplant		Uterus: Removal due to Cervical Cancer
	Kidney: Removal		

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Skin Disease History

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Check all that apply and indicate physician/surgeon who treated:

__ Basal Cell Skin Cancer: ____

__ Melanoma: (include location & date) ____

__ Squamous Cell Skin Cancer: ____

__ Other: ____

Do you wear sunscreen? (circle) Y/N – SPF: _____ Do you tan in a tanning salon? (circle) Y/N

Family History

Do you have a family history of melanoma? (circle) Y/N – Which relative/s: _______________________________

Medications

Do you take any prescriptive or herbal medications? (circle) Y/N

List:____
____

Allergies

Do you have any allergies? (circle) Y/N

List: (include reaction) ____

Social History

Smoking Status: (circle) Current every day smoker / Current some day smoker / Former Smoker / Never Smoker / Smoker, current status unknown / Unknown / Heavy tobacco smoker / Light tobacco smoker

Are you sexually active? (circle)Y/N – with one partner / with more than one partner / with same gender partner

(circle those that apply) Drug use/ IV Drug Use / Other: ______________

Do you consume alcohol? (circle) Y/N – How often? ______________

Do you feel safe at home? (circle) Patient feels safe at home / Patient feels unsafe at home

Do you exercise? (circle) Y/N – How often? _______________

Do you consume caffeine? (circle) Y/N – How often? ________________

Current Occupation: ___________________________________ Employer: _________________________________

Occupation prior to retiring: ____________________________

Place of Residence: _____________________________________

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Review of Systems

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Do you *currently* have any of the following?

Yes	No	(check answer to all that apply)	Yes	No	(check answer to all that apply)
		Problems with bleed			Bloody Stool
		Problems with healing			Bloody urine
		Problems with scarring (hypertrophic or keloid)			Joint aches
		Rash			Muscle weakness
		Immunosuppression			Neck Stiffness
		Hay Fever			Headaches
		Chest pain			Seizures
		Fever or chills			Cough
		Night sweats			Shortness of breath
		Unintentional weight loss			Wheezing
		Thyroid problems			Changing mole
		Sore throat			Anxiety
		Blurry Vision			Depression
		Abdominal Pain			

Do you have any of the following?

Yes	No	(check answer to all that apply)
		Allergy to adhesive
		Allergy to lidocaine
		Allergy to topical antibiotic ointments
		Artificial heart valve
		Artificial joints within the past two years
		Take blood thinners (including aspirin)
		Defibrillator
		MRSA (circle – history and/or current)
		Pacemaker
		Require premedication prior to procedures
		Rapid heartbeat with epinephrine
		Faint with procedures
		Pregnancy or planning a pregnancy

Pharmacy: ______________________________________ Address: ___________________________ City: _______________

I hereby authorize the above information is correct.

Patient/Responsible Party Signature: ____ Date: _______________ Revised 3/9/2016