

**PEAK TO PEAK FAMILY PRACTICE, P.C.**

**DAVID W. YAMAMOTO, M.D.**

*Please print and sign where indicated*

Acct. # _____
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Date \_\_\_\_/\_\_\_\_/\_\_\_\_

New

Update

_____ Last Name		_____ First Name		_____ Middle Initial	
_____ Street Address		_____ City	_____ State	_____ Zip	
Home Ph# ( ) _____ - _____	Work( ) _____ - _____	X _____	Cell( ) _____ - _____		
Date of Birth ____/____/____	Gender: <input type="radio"/> Male <input type="radio"/> Female	Social Security No. _____ - _____ - _____			
Marital Status: <input type="radio"/> Minor <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed		Employer: _____			

**If you checked Minor or Married, please complete the information below.**

_____ Spouse/Parent/Guardian Last Name		_____ First Name		_____ Middle Initial	
_____ Street Address (if different from above)		_____ City	_____ State	_____ Zip	
Home Ph# ( ) _____ - _____	Work( ) _____ - _____	X _____	Cell( ) _____ - _____		

**Please give the name of the nearest relative or friend not living with you to contact in case of emergency.**

_____ Name		_____ Relationship	
Home Ph# ( ) _____ - _____	Work( ) _____ - _____	X _____	Cell( ) _____ - _____

**Which pharmacy do you use? Name and Location:** \_\_\_\_\_

**Does the Patient have health insurance?**  Yes  No

**Is this visit related to a work injury or auto accident?**  Work Comp  Auto **Date of injury/accident:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT'S PRIMARY INSURANCE**

_____ Insurance Company	
_____ Address	
_____ Policy Holder's Name	_____ Social Security No.
_____ Relation to Patient	
_____ ID #	_____ Group #
_____ Adjuster Name (work comp/auto)	_____ Adjuster Phone #
_____ Claim # (work comp/auto)	

**PATIENT'S SECONDARY INSURANCE**

_____ Insurance Company	
_____ Address	
_____ Policy Holder's Name	_____ Social Security No.
_____ Relation to Patient	
_____ ID #	_____ Group #

**PEAK TO PEAK FAMILY PRACTICE, P.C.  
MEDICAL HISTORY INFORMATION**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  Male  Female

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Marital Status:  Minor  Single  Married  Divorced  Widowed Occupation \_\_\_\_\_

Please list any hobbies \_\_\_\_\_

**MEDICATIONS** (Please list all medications taken on a regular basis)

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**MEDICAL HISTORY**

Do you or have you ever had problems with any of the following?

- |   |  |
|---|--|
| <input type="radio"/> Arthritis                     | <input type="radio"/> Ulcers           |
| <input type="radio"/> Asthma                        | <input type="radio"/> Heartburn (GERD) |
| <input type="radio"/> Gout                          | <input type="radio"/> Headaches        |
| <input type="radio"/> Rheumatic Fever               | <input type="radio"/> Epilepsy         |
| <input type="radio"/> Spine/back Problems           | <input type="radio"/> Stroke           |
| <input type="radio"/> Allergic Rhinitis (hay fever) | <input type="radio"/> Breast Cancer    |
| <input type="radio"/> Lung Disease (type) _____     | <input type="radio"/> Ovarian Cancer   |
| <input type="radio"/> Heart Attack (MI)             | <input type="radio"/> Colon Cancer     |
| <input type="radio"/> Heart Failure                 | <input type="radio"/> Prostate Cancer  |
| <input type="radio"/> Coronary Artery Disease       | <input type="radio"/> Kidney Disease   |
| <input type="radio"/> Elevated Cholesterol          | <input type="radio"/> Kidney Stones    |
| <input type="radio"/> Diabetes                      | <input type="radio"/> Depression       |
| <input type="radio"/> High Blood Pressure           | <input type="radio"/> Anxiety          |
| <input type="radio"/> Thyroid Disease               | <input type="radio"/> Anemia           |
| <input type="radio"/> Gall Bladder Disease          | <input type="radio"/> Hepatitis        |
| <input type="radio"/> Irritable Bowel Syndrome      | <input type="radio"/> Blood Clots      |
| <input type="radio"/> Colitis                       |  |
| <input type="radio"/> Other _____                   |  |
| <input type="radio"/> Other _____                   |  |

**ALLERGIES**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**FAMILY HISTORY**

Please list any major health problems that your parents, grandparents or siblings have had.

Person Affected/ age at diagnosis

Heart Attack
Stroke
Colon Cancer
Breast Cancer
Ovarian Cancer
Prostate Cancer
Lung Cancer
Diabetes
Hypertension
Depression/Anxiety
Bipolar
Alcoholism
Blood Clot
Other
Other

**GYNECOLOGICAL HISTORY**

Are you sexually active? Y N  
 Do you use contraception? Y N Type \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Date of first day of last period \_\_\_\_\_

**IMMUNIZATIONS**

Please note the most recent date if known:  
 Tetanus Year: \_\_\_\_\_  
 Influenza (flu shot) Year: \_\_\_\_\_  
 Pneumonia (Pneumovax) Year: \_\_\_\_\_

**SURGICAL HISTORY**

Type _____	Year _____
_____	_____

**TRAUMA HISTORY**

Please describe any serious head injuries, fractures, or accidents you have had.  
 Type \_\_\_\_\_ Year \_\_\_\_\_

Siblings: # of Brothers \_\_\_\_\_ # of Sisters \_\_\_\_\_  
 Children: # of Sons \_\_\_\_\_ # of Daughters \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? Y N If yes, how much? \_\_\_\_\_  
 Do you drink alcohol? Y N If yes, how much? \_\_\_\_\_  
 Do you use recreational drugs? Y N  
 Do you exercise regularly? Y N Are you sexually active? Y N  
 Your sleeping habits are: Good Fair Poor  
 The quality of your life is: Good Fair Poor