704 N. Alpha Street (308)384-5700

Today's date: __________________

Full Name: ______________________________________ **Social Security Number**: ______________________

Date of Birth: ___________________ **Age:** _______ **Gender**: ☐ Male ☐ Female ☐ Other _________

Mailing Address: ____________________________________ **Home Phone**: ____________________________

Physical Address: ___________________________________ **Mobile Phone**: ____________________________

City/State/Zip: ___________________________________ **Preferred contact method:** ☐ Call ☐ Text ☐ Email

Email Address *(required)*: ____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other_________

If married: Can we release Protected Health Information to your spouse: ☐ Yes ☐ No

Spouse's Name & Phone: ____

Race: ☐ White ☐ Black ☐ Native ☐ Asian ☐ Other: _______________

Ethnic group: ☐ Hispanic ☐ Not Hispanic

Language: ☐ English ☐ Spanish Other___________

Primary Care Physician: _________________________________ Clinic:________________________________

Referring Physician: ____________________________________ Clinic:________________________________

Pharmacy Name and City: ____

Patient Employer: ______________________________ Phone: __________________ ☐Full-time ☐Part-time

If patient is 18 years of age or younger:

Mother's Name: ________________________________ Birth Date: ____________ Phone: _______________

*Mother's Employer: _____________________________________ Phone: _______________

Father's Name: _________________________________ Birth Date: ____________ Phone: _______________

*Father's Employer: ______________________________________ Phone: _______________

Social History:

Smoking: ☐Never-Smoked ☐Current Smoker-pack per/day_____ ☐Former Smoker-years smoked_____

Alcohol: ☐none ☐ less than 1 drink/day ☐ 1-2 drinks/day ☐ 3 or more/day

Women: How many times in the past year have you had 4 or more drinks/day _____

Men: How many times in the past year have you had 5 or more drinks/day _____

Do you use recreational drugs? ____

Family History:

Do you have a family history of Thyroid Disease? Y N If yes, which relative? ______________

Do you have a family history of skin cancer? Y N If yes, which relative? ______________

Family History of any anesthesia complications? Y N If yes, which relative? ______________

Today's date: __________________ **Patient name:** __________________________ **DOB:** _________________

List of medications: (please include dosage and OTC drugs/supplements)

____

____

____

____

____

Allergies: ____

____

General Medical History: (check all that apply past or present)

☐Asthma ☐Sleep apnea ☐COPD ☐CPAP ☐Bleeding/clotting issues __________ family history of __________

☐High Blood Pressure ☐History of A-fib ☐History of stroke ☐Kidney disease ☐AIDS/HIV ☐Hepatitis

☐Diabetes ☐Migraine ☐Osteoporosis ☐Anesthesia complications__________________

☐Heart surgery_________________ ☐Pacemaker (please show card) ☐Joint replacement______________

☐Other____

Previous surgeries: ____

____

Patients age 64 and older only:

Do you have a health care proxy? (a legal document appointing someone to make healthcare decisions on your behalf)

☐ No

☐ Yes-please provide details:

Name: ____

Phone #: ____

Do you have a living will? ☐ Yes ☐ No

(a legal document that specifies the medical treatments you would or would not want to receive if you are unable to make decisions for yourself. It also outlines preferences for other medical decisions, such as pain management or organ donation)

Which statement(s) best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Have you received a pneumonia vaccination on or after your 60th birthday? ☐ Yes ☐ No

____

Patient Signature/Responsible Party Date