STERLING HEALTH SOLUTIONS

To speed up the check in process, please fill in ALL information

Please check the site where you are wanting to be seen:

☐ ***Sterling Health Care*** ☐ ***Sterling Women's Care*** ☐***Bath Family Health Services***

Last Name: _____ **First Name**: _____ **Middle Name:** _____

Gender: M/F **SSN:** _____ **Birth Date:** _____ **Nickname:** _____

Marital Status: □Divorced □Married □Separated □Single □Unknown □Widow
Race: □American Indian/Alaskan Native □Asian □Black/African American □Native Hawaiian □White □ Other
Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino

Address: _____ **Zip Code**: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Preferred Communication**: Phone/Email

Preferred Phone Contact: □Home □Cell □Work **Preferred Language:** □English □Spanish □Interpreter Needed
Living Arrangements □ Alone □Family □Institution □Relative □Roommates □Spouse Only
Living Situation □ Homeless □Transitional □Doubling Up □Street □Other □Unknown □Not Homeless
Agricultural Worker □ Migrant □Seasonal **Are you a Veteran** □Yes □No

Who is/was your Primary Care Provider? _____

Reason for transferring care, if transferring care _____

In case of Emergency, please contact:

Name _____ **Phone:** _____ **Relation:** _____

Address _____

Pharmacy: _____

INSURANCE INFORMATION:

Primary Insurance: _____ **ID#** _____ **GROUP#** _____

Secondary Insurance: _____ ID# _____ GROUP# _____

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

Subscriber Gender: ____ **Subscriber Phone** _____

Subscriber Address if different from Patient: _____

EMPLOYMENT INFORMATION
□Full-time □Part-time □Unemployed □Full-time Student □Part-time Student
□Retired □Unknown □Active Military Duty

Employer Name: _____ **Employer Phone**: _____

Employer Address: _____

HOUSEHOLD INCOME INFORMATION

What is you annual household income? **How many people are in your household? _____**

☐No income ☐Less than 24,999 ☐25,000 to 39,999 ☐40,000 to 59,999 ☐60,000 to 99,999 ☐100,000 or more

Are you seeking treatment that is related to a Worker Compensation or Auto Accident injury? ☐Yes ☐No

MEDICAL INFORMATION

Please list any medical conditions that you are currently being treated for: _____

_____

_____

ALLERGIES

Medications	
Vaccines	
Food	
Other	

Serious injuries or accidents: _____

_____

Please list any operations you have had:

Year occurred	**Operation / Surgery**

Please list other doctors you see and why you see them:

Provider / Doctor	**Condition / Reason you see them**

Do you require treatment/medication for chronic pain? ☐Yes ☐No

How were you referred to Sterling Health? _____

Have you ever had a heart catheterization? ☐Yes ☐No If so, when? _____

Have you ever had any arterial stents placed? ☐Yes ☐No If so, when? _____

Have you ever had a colonoscopy? ☐Yes ☐No If so, when?_____ where_____

IMMMUNIZATION HISTORY

Please indicate the date of the following vaccinations:

Vaccination	Date of Immunization
Influenza (flu)	
Pneumonia	
Tetanus/Tdap	
Hepatitis B	
Hepatitis A	
Shingles	

FOR FEMALES ONLY

Are you pregnant or could you be? ☐Yes ☐No Date of last menstrual period_____

Have you had a hysterectomy? ☐Yes ☐No If yes, when_____

Do you regularly have a PAP smear? ☐Yes ☐No Date of last test_____

Do you regularly have a mammogram? ☐Yes ☐No Date of last test_____

How many children born alive? _____ How many miscarriages? _____

How many stillbirths? _____ How many Cesarean operations? _____

How many premature births? _____ Any complications of pregnancy? _____

FAMILY HISTORY

Please list Health Conditions experienced by relatives (mark only those that apply):

Condition	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)	**Condition**	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)
Heart Attack	Age:	Colitis	
High Blood Pressure		Crohn's Disease	
Congestive Heart Failure		Colon Polyps	
Rheumatic Heart Disease		Hepatitis	
Congenital Heart Disease		Stomach Ulcer	
Breast Cancer	Age:	Kidney Disease	
Colon Cancer	Age:	Stroke	
Leukemia		Migraine	
Melanoma (skin cancer)		Seizures	

Ovarian Cancer		Diabetes	
Pancreatic Cancer		Goiter	
Any other Cancer		Bleeding Tendency	
Asthma		Suicide	
Tuberculosis		Mental Illness	
Other		Drug or Alcohol Abuse	

PERSONAL HABITS

Do you Smoke? ☐Yes ☐No What do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars

How long have you smoked? _____ How many packs per day? _____

Have you regularly smoked in the past? ☐Yes ☐No When did you quit? _____

Have you ever used recreational drugs? ☐Yes ☐No When? _____ What? _____

Do you regularly drink alcohol? ☐Yes ☐No

Beer: Number of bottles or cans per day_____

Wine: Number of glasses per day_____

Liquor: Number of ounces per day_____

Have you had 6 or more drinks of alcohol during a drinking session in the past year? ☐Yes ☐No

Have you had more than one sexual partner in the last 24 months? ☐Yes ☐No

Has the person you live with hit you or hurt you physically in the past? ☐Yes ☐No

Has any person verbally abused you? ☐Yes ☐No

Is there anything further you think we need to know about you? If so, please explain in the space provided below.

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:_____**

Please list ALL medications:

Medication	Dosage/Strength	Frequency/Doses per day