



www.TheAlpineClinic.com

The Alpine Clinic, PLLC

A division of Littleton Regional Healthcare



PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: ____ / ____ / ____ AGE: ____ SEX: **MALE** / **FEMALE** SSN: _____

MAILING ADDRESS:

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER:

EMAIL:

RACE: _____ RELIGION _____

EMERGENCY CONTACT:

RELATIONSHIP:

PHONE:

PRIMARY CARE PHYSICIAN:

PRACTICE NAME:

PHONE:

CITY:

STATE:

PHARMACY:

LOCATION:

DO YOU HAVE A Power Of Attorney? YES / NO

POA NAME:

Please provide a copy of the POA to The Alpine Clinic.

POA PHONE:

GAURDIAN 1 NAME:

GAURDIAN 1 ADDRESS:

HOME PHONE:

CELL PHONE:

WORK PHONE:

GAURDIAN 2 NAME:

GAURDIAN 2 ADDRESS:

HOME PHONE:

CELL PHONE:

WORK PHONE:

INSURANCE TYPE:

SUBSCRIBER NAME: _____ SUBSCRIBER

DOB: _____



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MEDICAL HISTORY

NAME: _____ DOB: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ OCCUPATION: _____

Current Medications

NAME	DOSAGE	FREQUENCY

Past Surgeries

DATE	DESCRIPTION

Allergies

Medical Symptoms Today (check all that apply):

- Fever
- Chills
- Weight Loss
- Weight Gain
- Numbness
- Tingling
- Hearing Loss
- Vision Loss
- Headaches
- Blurry Vision
- Difficulty Swallowing
- Ringing in Ears
- Upper Respiratory Infection
- Irregular Heartbeat
- Heart Murmur
- Chest Pain
- Skipping Heartbeat
- Shortness of breath
- Trouble breathing
- Cough
- Sputum
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Reflux/Heartburn
- Itching (urinal)
- Burning (urinal)
- Hesitancy (urinal)
- Frequency (urinal)
- Foul odor (urinal)
- Change in mood
- Depression
- Anxiety

Past and Current Medical Problems (check all that apply):

- Arthritis/Joint Pain
- Asthma/Wheezing
- Clotting Problem
- Cancer/Tumor
- Diabetes
- Emphysema
- Fainting
- Fibromyalgia
- Gout
- Heart Attack
- High Blood Pressure
- High Cholesterol
- HIV (positive for AIDS)
- Limited Neck Motion
- Pacemaker
- Poor Circulation
- Seizures
- Stroke
- Ulcers
- Other:

Tobacco Use: NO YES

Alcohol Use: NO YES

Type: _____

Type: _____

Number of years:

Frequency: _____

Packs per day: _____

Year quit: _____
-

Year quit: _____
-

Hobbies/Sports

Do you have access to exercise equipment? NO YES

Family History (please check all that apply):						
	MOTHE R	FATHER	MOTHER'S MOTHER	MOTHER'S FATHER	FATHER'S MOTHER	FATHER'S FATHER
Heart Attack						
High Cholesterol						
High Blood Pressure						

Arthritis/Osteoarthritis						
Rheumatoid Arthritis						
Diabetes						
Bleeding/Clotting Problems						
Osteoporosis						