WASHINGTON HEALTH SYSTEM
Primary Care - Lakeside

In order for us to get to know you and your health care needs, please fill out the following form to the best of your ability. Our goal is to provide you with exceptional health care, and it starts with getting to know you.

NAME:________________________________DATE OF BIRTH:________________________AGE:________

Please let us know how you heard about our practice. Check all the ways that we have caught your attention.

Billboards__________________________ **Website____________________** **Radio Commercial_____________**

Magazine ads_______________________ **Google search______________________** **Insurance Company_________________**

Mailing ___________________________ **Personal referral____________________** **Previous patient of the physician_________________**

Other - Please tell us where…

____

Our organization takes care of people with different needs and we make every attempt to make all feel comfortable and welcome. During the registration process you will be asked questions about information that may impact your health care, including Race, Ethnicity, Sex and Sex at Birth.

Please circle the best response:

Race Information (Please circle): White Black/African American Asian Alaskan or Native American Hawaiian or Pacific Islander Hispanic/Latino More than one race I prefer not to disclose

What was the gender on your birth certificate? Please circle: Male Female Unknown

Sexual orientation (PLEASE CHECK):		**Gender identity (PLEASE CHECK):**	
Lesbian, Gay, or Homosexual		Male	
Straight or Heterosexual		Female	
Bisexual		Female to Male/Transgender Male	
Do Not Know		Male to Female/Transgender Female	
Choose Not to Disclose		Genderqueer; neither exclusively male	
Something else; describe		Choose not to disclose	
		Other category;	

OCCUPATION:_______________________**MARITAL STATUS**: S M D W OTHER________________

whsdocs.org whslakeside.org
1001 Waterdam Plaza Drive, McMurray, PA p: (724) 969-1001

WHO RESIDES WITH YOU IN YOUR HOME (PLEASE INCLUDE - NAME, AGE, AND RELATIONSHIP TO YOU)

MEDICAL HEALTH HISTORY

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (PLEASE INCLUDE NAME AND DOSAGE)

PLEASE CHECK BOX TO THE RIGHT IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

ALCOHOL ABUSE		GLAUCOMA		OSTEOPOPENIA	
ALLERGIES		GOUT		OSTEOPOROSIS	
ASTHMA		GERD (REFLUX)		PALPITATIONS	
ANEMIA		HEADACHES		PSORIASIS	
ANXIETY		HEART DISEASE		PROSTATE	
ARTHRITIS		HEART MURMUR		PROSTATITIS	
BACK PAIN		HEMORROIDS		RHEUMATIC FEVER	
COPD		HEPATITIS		SCIATICA	
CANCER		HIGH BLOOD PRESSURE		SEXUAL	
CONSTIPATION		HIGH CHOLESTEROL		STOMACH ULCERS	
CROHN’S DISEASE		HYPERTHYROIDISM		STROKE (CVA)	
DEPRESSION		HYPOTHYROIDISM		SWOLLEN ANKLES	
DIABETES TYPE I		INSOMNIA		SEIZURES	
DIABETES TYPE II		IRRITABLE BOWEL		STD	
DIVERTICULITIS		KIDNEY STONES		TUBERCULOSIS	
DRUG ABUSE		KIDNEY DISEASE (RENAL		RECURRENT UTI’S	
FIBROMYALGIA		LIVER DISEASE		ULCERATIVE COLITIS	
GALL BLADDER		MELANOMA		OTHER:	

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ARE YOU ALLERGIC TO ANYTHING?
(PLEASE LIST ALL ALLERGIES-MEDICATIONS, DYES, ENVIRNOMENTAL, TAPE, ETC… AND THE REACTION IT CAUSES)

PLEASE LIST ANY PRIOR SURGERIES (INCLUDE DATE IF KNOWN):

TYPE OF SURGERY	DATE

FAMILY HISTORY:

PLEASE COMPLETE TABLE INDICATING MEDICAL HISTORY OR FAMILY MEMBERS TO THE BEST OF YOUR KNOWLEDGE:

	Alive Y/N	AGE	DIABETES	HEART DISEASE	CANCER	MENTAL ILLNESS (ANXIETY, DEPRESSION ETC)	DRUG & ALCOHOL ADDICTION	BLOOD CLOTS	BLEEDING DISORDER	HIGH BLOOD PRESSURE	OTHER PLEASE LIST
FATHER											
MOTHER											
SISTER											
BROTHER											
SON											
DAUGHTER											
PATERNAL GRANDFATHER											
PATERNAL GRANDMOTHER											
MATERNAL GRANDFATHER											
MATERNAL GRANDMOTHER											
AUNT/UNCLE											
OTHER											

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PLEASE ANSWER THE FOLLOWING:

DO YOU SMOKE?	NO	YES	IF YES-EVERY DAY? SOME DAYS? HOW MUCH PER DAY?
FORMER SMOKER?	NO	YES	IF YES, WHEN DID YOU QUIT?
CHEWING TOBACCO?	NO	YES	IF YES, EVERY DAY? SOME DAYS? HOW MUCH PER DAY?
NON-TOBACCO NICOTINE CONTAINING PRODUCTS?	NO	YES	IF YES, WHICH PRODUCT? HOW MUCH PER DAY?
DO YOU DRINK CAFFEINATED BEVERAGES?	NO	YES	IF YES-HOW MANY CUPS PER DAY?
DO YOU DRINK ALCOHOL?	NO	YES	IF YES-HOW MUCH PER WEEK?
DO YOU USE ILLEGAL DRUGS?	NO	YES	IF YES- WHAT KIND AND HOW OFTEN?
ARE YOU AT RISK FOR HIV?	NO	YES	IF YES-WHY?
ARE YOU IN AN ABUSIVE RELATIONSHIP?	NO	YES	IF YES- IS IT VERBAL OR PHYSICAL?
DO YOU EXERCISE?	NO	YES	IF YES-WHAT TYPE?
DO YOU WATCH YOUR DIET?	NO	YES	IF YES-FOR FAT/CHOLESTEROL/SALT/OTHER?

HAVE YOU HAD ANY OF THE FOLLOWING IMMUNIZATIONS?

INFLUENZA (FLU)	NO	YES	UNSURE	DATE:
PNEUMONIA	NO	YES	UNSURE	DATE:
TETANUS	NO	YES	UNSURE	DATE:
HEPATITIS B	NO	YES	UNSURE	DATE:
HPV (GARDASIL)	NO	YES	UNSURE	DATE:
SHINGRIX	NO	YES	UNSURE	DATE:
COVID	NO	YES	Manufacturer:	DATES:

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PLEASE SHARE WITH US ANY OTHER PHYSICIANS THAT YOU SEE ON A REGULAR BASIS (NAME AND SPECIALITY):

FEMALE PATIENTS PLEASE COMPLETE THE FOLLOWING:

WHEN WAS YOUR LAST:

PAP SMEAR:____

MAMOGRAM:____

BREAST EXAM:____

BONE DENSITY TEST:____

COLONOSCOPY:____

FIT TEST/COLOGUARD:____

AGE MENSTRUAL CYCLE BEGAN:____________________ FREQUENCY:___________________________________

LENGTH OF PERIODS:_____________________________ LAST MENSTRUAL PERIOD:______________________

PREGNANCIES:______________________________ BIRTHS:______________ MISCARRIAGES:______________

DO YOU USE BIRTH CONTROL?:______________________ WHAT METHOD?:____________________________

ARE YOU CURRENTLY BREAST FEEDING?__________________HISTORY OF BREAST FEEDING:________________

DO YOU HAVE A HISTORY OF:

PROLONGED OR ABNORMAL BLEEDING	NO	YES-PLEASE EXPLAIN
LEAKAGE OF URINE	NO	YES-PLEASE EXPLAIN
PELVIC PAIN	NO	YES-PLEASE EXPLAIN
ABNORMAL DISCHARGE	NO	YES-PLEASE EXPLAIN

MALE PATIENTS PLEASE COMPLETE THE FOLLOWING:

WHEN WAS YOUR LAST:

COLONOSCOPY:____

FIT TEST/COLOGUARD:____________________________________

Thank-you for completing all of the requested information. We look forward to getting to know you and taking care of you in an environment that is designed with your health care needs in mind.