Dr. Michael S Duffy SR, DO
1501 5th Avenue Suite #100
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Office: 619-461-3717 Fax: 619-461-5663

Established Patient Demographic / Medical Update

Patient Name: _____ Date: _____
Patient DOB: _____ □Male □ Female
Email Address: _____
Address:_____
Phone:_____ Cell / Home
Emergency Contact (Number and Relation):
_____

Have you had any Changes to your Insurance Policy since your last appt.? If so Please List below
Primary Insurance: _____Policy #_____Group_____
Are you the Cardholder □ Yes □ No Cardholder _____Relation_____
Secondary Insurance: _____Policy #_____Group_____
Are you the Cardholder □ Yes □ No Cardholder _____ Relation_____
Social Security Number: _____
……
Primary Care Physician: _____ Phone Number:_____
……

Any Changes to your Medical History

1. Allergies (Please list all): _____
   _____
   _____
2. If you require assistance to walk what device do you use:
   _____
   _____
3. Nutritional Status (do you have any new dietary needs):
   _____
4. What prescription Medication, Over the Counter(OTC's) and/or Herbals are you currently taking?

Medication Name	Medication Strength	Medication Dosage

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5. Who do you use for your primary Pharmacy?

Name	Address	Phone Number

6. Are you currently seeing any new providers? □ Yes □No If So please list their Name and Specialty.

Physician Name	Specialty	Phone # if Known

7. Present Medical Complaint: _____
_____
_____

8. Any New Medical History, Major Illness, Hospitalization, Surgeries (include dates):
_____
_____

9. Any New Trauma (Physical/ Sexual/ Verbal): □ Yes □No, If yes please describe:
_____
_____

10. Changes in Psychiatric History: □ Yes □ No If Yes Please explain:
_____
_____

Changes to Any of your Body Systems

……

Please list any problems that you have with the following body system:
Ears/ Nose/ Throat: □Do not have any problem □Have the following
_____
_____

Eyes: □Do not have any problem □Have the following
_____
_____

Lungs: □Do not have any problem □Have the following
_____
_____

Liver: □Do not have any problem □Have the following
_____
_____

G-I Tract (Stomach, Intestines, Bowels, Etc.): □Do not have any problem □Have the following
_____
_____

Kidney/ Bladder: □Do not have any problem □Have the following
_____
_____

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Reproductive System: □Do not have any problem □Have the following

_____

_____

Skin: □Do not have any problem □Have the following

_____

_____

Neurological: □Do not have any problem □Have the following

_____

_____

Heart/ Circulation: □Do not have any problem □Have the following

_____

_____

Psychological (Depression, Anxiety, and Anger Etc.): □Do not have any problem □Have the following

_____

_____

……

Off Work Activities

……

Do you Exercise? □Yes □No if yes please describe the type of exercise and the frequency you exercise. If no, please explain why you do not exercise:

_____

_____

Do you participate in any sports, or new physical activity? □ Yes □No If yes, please describe type and the frequency you participate in the activity:

_____

_____

Do you have any hobbies? □ Yes □NO If yes please describe type and the frequency you do hobbies:

_____

_____

Are you able to perform your normal/ regular house/ yard chores/ activities?
□Yes □No If no please explain what you cannot do and why:

_____

_____

……

Social History

……

Are you: □Married □Single □Separated □Divorced □Separated □Divorced □Widowed If married, how many years: ____ If separated, how many years? ____ If divorced, how many years? ____ If widowed, how many years? _____

How many years of schooling do you have? _____

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Did you have problems in school? □Yes □No If yes, please explain (How, What, Who With):

_____

_____

_____

What is the highest degree you earned?
□GED □High School Graduate □BS □MS □Doctorate □Other:_____

What New licenses/ certifications do you have:

_____

_____

Do you use alcohol? □Yes □No If yes, how many drinks per week? _____
If Quit When and how much did you consume_____
Do you use Tobacco? □Yes □No If yes, how many times per day? _____
If Quit When and how many Packs per Day_____
If Interested in quitting have you tried anything so far □Yes □No
Have you set a quit date □Yes □No Date: _____
Would you like info on smoking cessation □Yes □No
Do you chew Tobacco? □Yes □No If yes, how many times per day? _____
If you Quit When and How much did you Use_____
If Interested in quitting have you tried anything so far □Yes □No
Have you set a quit date □Yes □No Date: _____
Would you like info on smoking cessation □Yes □No

Do you use medical Marijuana? □Yes □No If yes how often and how much?

_____

Do you use any other kind of drugs? □Yes □No If yes, what kind and how often?

_____

_____

List any other Habits that you have, describing their types and frequency:

_____

_____

……

Any other Concerns for your Provider today?

_____

_____

_____

_____

_____

_____

Signature_____ Date_____