Quality care you deserve.

good health family medicine

1339 West 6th Street, Erie, PA 16505
Telephone 814-480-8170
FAX 814-480-8175

PATIENT INFORMATION:

LAST NAME _____FIRSTNAME_____MI ___
ADDRESS _____CITY_____STATE____ZIP_____
PHONE _____CELLPHONE_____
BIRTHDATE _____SOC SEC#_____
MARITAL STATUS: S M W D E-MAIL ADDRESS_____
EMPLOYER_____WORKPHONE_____
WORK ADDRESS_____CITY_____STATE____ZIP_____
JOB DESCRIPTION:_____

INSURANCE SUBSCRIBER INFORMATION:

(CHECK IF SAME AS ABOVE ☐)
LAST NAME _____FIRSTNAME_____MI ___
ADDRESS _____CITY_____STATE____ZIP_____
PHONE _____CELLPHONE_____
BIRTHDATE _____SOC SEC#_____
MARITAL STATUS: S M W D E-MAIL ADDRESS_____
EMPLOYER_____WORKPHONE_____
WORK ADDRESS_____CITY_____STATE____ZIP_____
JOB DESCRIPTION:_____

GUARANTOR INFORMATION: person responsible for payment

(CHECK IF SAME AS PATIENT ☐ OR INSURANCE SUBSCRIBER ☐)
LAST NAME _____FIRSTNAME_____MI ___
ADDRESS _____CITY_____STATE____ZIP_____
PHONE _____CELLPHONE_____
BIRTHDATE _____SOC SEC#_____
MARITAL STATUS: S M W D E-MAIL ADDRESS_____
EMPLOYER_____WORKPHONE_____
WORK ADDRESS_____CITY_____STATE____ZIP_____
JOB DESCRIPTION:_____

How did you hear about us? _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS AUTHORIZATION OR PHOTOCOPY HERE OF, AUTHORIZES

_____

TO FURNISH ALL INFORMATION THEY MAY HAVE REGARDING MY (OUR) CONDITION(S) WHILE UNDER THEIR DOCTOR OBSERVATION OR TREATMENT. INCLUDING, BUT NOT LIMITED TO, HISTORY OBTAINED, RADIOLOGIST, LABORATORY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS.

I UNDERSTAND THIS RELEASE WILL NOT RESTRICT THE DISCLOSURE OF INFORMATION PERTAINING TO DRUG OR ALCOHOL ABUSE, PSYCHIATRIC CONDITIONS, A BLOOD TEST FOR AIDS OR AN AIDS DIAGNOSIS AND TREATMENT.

PLEASE TRANSFER MY COMPLETE MEDICAL RECORDS TO:

GOOD HEALTH FAMILY MEDICINE
DR. MICHELE POLON
1339 W. 6TH STREET
ERIE, PA 16505

NAME OF PATIENT	DATE OF BIRTH
1.	
2.	
3.	
4.	
5.	
6.	

SIGNED:_____ **DATE:**_____

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PATIENT NAME: _____ **DOB:** _____

Appointment Date/Time with Dr Michele Polon: _____

Social History:
Marital Status: □married, □single, □widowed, □divorced, □in a long term relationship
Education Level: □grade school, □high school, □GED, □college, □advanced degree
Tobacco: □non-smoker, □ex-smoker year quit_____, □current smoker/chew user _____Packs/cans per day, □cigar smoker_____ cigars per day
Alcohol: □Abstains, □alcohol usage…beer _____cans per day/week, wine _____ glasses per day/week, mixed drinks _____ per day/week
Drug use: □marijuana, □barbiturates, □cocaine, □narcotics, □other_____

Past Medical History:

_____

_____

Chronic problems:

	Year Diagnosed	Other Problems	Year Diagnosed
Arthritis			
Cancer			
COPD/Emphysema			
CVA or stroke			
Depression			
Diabetes, Type 1			
Diabetes, Type 2			
GERD			
Heart Disease			
Hyperlipidemia			
Hypertension			
Kidney Stones			
Mental illness			
Migraines			
Sleep Apnea			
Thyroid disease			

Past Surgical History:

Pending or upcoming surgeries: none

Past Psychiatric History: (examples: depression, bulimia, anxiety)
 none

Medications:	**Strength:**	**Dose: (daily, twice a day, etc)**

Vitamins/Herbals:	**Strength:**	**Dose: (daily, twice a day, etc)**

Allergies: none

Medication	**Reaction**

Exposures: if yes, please supply date and information.
 Yes No Tuberculosis:
 Yes No Hepatitis:
 Yes No Sexually Transmitted Diseases:
 Yes No HIV :
 Yes No Chemicals:
 Yes No Silica:
 Yes No Fiberglass:
 Yes No Asbestos:
 Yes No Radiation:
 Yes No Chemotherapy:
 Yes No Other:

Living Will: Do you have a Living Will? □ Yes □ No …if yes, we need a copy.

FAMILY HISTORY:

	None	Mother	Father	Sibling add name	Maternal Grand-Mother	Maternal Grand-Father	Paternal Grand-Mother	Paternal Grand-Father	Other
Living (L) or Deceased (D)									
Cancer (specify type)									
COPD									
CVA or Stroke									
Depression									
Diabetes, Type 1									
Diabetes, Type 2									
Immune Deficiency									
Heart Disease									
Hyperlipidemia									
Hypertension									
Mental illness									
Myocardial Infarction									
Thyroid disease									

For Females only:

Past OB/GYN History:
Menarche: age at onset of menstrual period:_____
Menopause: □ N/A, □ Natural at age_____, □ Surgical at age _____ (list surgery above)

History of Birth Control. □ none

	Currently Using	Prior Usage
Birth Control Patch		
Condoms		
Depo-Provera Shots		
Diaphragm		
Implants		
IUD		
NuvaRing		
Oral contraceptives		
Vasectomy		

Regular **GYNECOLOGIST** is: □ Dr Polon, □ other:_____

Pregnancy History:
Do you have any children: □ Yes □ No

Name:		**Date of Birth:**	**Vaginal or Cesarean Delivery**
	M/F		
	M/F		
	M/F		

Please fax or mail this Health History form to our office, prior to your appointment.
Please bring the following with you to your appointment:

1. Insurance Cards
2. Immunization Record
3. Living Will/Power of Attorney, if applicable
4. Patient Data form (this can be faxed or mailed also)
5. Records Release form(this can be faxed or mailed also)

We look forward to seeing you and maintaining your good health.
All forms, along with our office policies can be printed from our website or requested from our staff.

WWW.goodhealthfamilymedicine.com