



DUBLIN MEDICAL CENTER
FAMILY MEDICINE

ROBERT A. DAVIS, MD *Family Practice*

Robert A. Davis, MD
Joy M. Davis, MSN, CRNP
Natasha L. Worthington, PA-C

Patient Information -

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____
 Previous Last Name: _____ Marital Status: S M D W DP
 Occupation: _____ Employer: _____
 Nickname: _____ Spouse Name: _____
 Parent/Legal Guardian Name: _____
 State/Country of Birth: _____ Special Communication Needs: _____

Language: _____ Race: _____ Decline Ethnicity: _____ Decline

Patient Contact Information -

Copy of Driver's License Provided

Address: _____ City: _____
 State: _____ Zip: _____ County: _____ Preferred Phone Number: _____
 Is this phone number? Cell Home Work May we leave detailed messages at this phone? NO YES
 Secondary Phone: _____ Email: _____

Emergency Contact Information -

Name	Relationship	Phone Number	Address

I hereby authorize **Doylestown Healthcare Partnership** to discuss and or release my PHI (protected health information) to: **Myself Only**

Name	Relationship	Phone

Advanced Care Directive - Do you have an Advance Directive or Living Will? NO YES

Have you designated a Durable Power of Attorney? NO YES *If yes, please enter information below:*

Name	Relationship	Phone Number	Date

Specialist Contact Information - (Please provide first and last names)

	Physician Name	Office Name	Location
Cardiologist:			
Eye Doctor:			
Gynecologist:			
Endocrinologist:			
Urologist:			
Other:			



DUBLIN MEDICAL CENTER
FAMILY MEDICINE

ROBERT A. DAVIS, MD *Family Practice*

Robert A. Davis, MD

Joy M. Davis, MSN, CRNP

Natasha L. Worthington, PA-C

Patient Name: _____ **Date of Birth:** _____

Adult Vaccination/Immunization History - (If available please attach childhood immunizations separately)

	Date		Date		Date
Tetanus		Zoster		Prevnar 13	
TDAP		Shingrix		Pneumovax 23	

Health History - Have you ever been diagnosed with any of the following:

Reconciled

<input type="checkbox"/> Measles/ Mumps	<input type="checkbox"/> Gout	<input type="checkbox"/> Seizures / Epilepsy	<input type="checkbox"/> Bone/Joint Disorder	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Reflux Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Emphysema / COPD
<input type="checkbox"/> Polio	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Pulmonary Clotting
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart Disease / CAD	<input type="checkbox"/> Urinary Disorders	<input type="checkbox"/> Depression
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Reproductive Issues	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Vaginal Infection	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Migraines/Headache	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Cancer	<input type="checkbox"/> Autoimmune Disease		<input type="checkbox"/> Skin Disease	<input type="checkbox"/> STD
Type:	Type:	Disease	Type:	Type:
Other Health Conditions:				
Blood Transfusion: <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, date: _____ Reason: _____				

FAMILY HISTORY -

Details Attached

Adopted

Reconciled

Relation	Current Age, if living	Age at Death	High Blood Pressure	Heart Disease	Stroke	Cancer	Diabetes	Glaucoma	Asthma	Seizures	Bleeding Disorder
Father			<input type="checkbox"/>								
Mother			<input type="checkbox"/>								
Maternal Grandmother			<input type="checkbox"/>								
Maternal Grandfather			<input type="checkbox"/>								
Paternal Grandmother			<input type="checkbox"/>								
Paternal Grandfather			<input type="checkbox"/>								
Sibling			<input type="checkbox"/>								
Sibling			<input type="checkbox"/>								
Other relative			<input type="checkbox"/>								

Surgical History - None

Details Attached

Reconciled

Procedure	Date

Current Medications with Dosages - None

Details Attached

Reconciled



SOCIAL HISTORY - Details Attached

Reconciled

Tobacco Use: <input type="checkbox"/> YES <input type="checkbox"/> NO Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Chew Amount per day: _____ Number of years you have used tobacco: _____ Former tobacco user: <input type="checkbox"/> YES <input type="checkbox"/> NO Last tobacco use: _____	Alcohol Consumption: <input type="checkbox"/> YES <input type="checkbox"/> NO Number of drinks per week: _____ Preferred drink (ie: beer, wine, spirits): _____ _____ <input type="checkbox"/> QUIT Years quit: _____	Recreational Drug Use: <input type="checkbox"/> YES <input type="checkbox"/> NO Type: _____ Amount per week: _____ Last used: _____ <input type="checkbox"/> QUIT Years quit: _____
Caffeine: <input type="checkbox"/> YES <input type="checkbox"/> NO # of caffeine drinks per day: _____	Regular Exercise: <input type="checkbox"/> YES <input type="checkbox"/> NO Type exercise: _____ How often: _____	Do you share a home with anyone else? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Friend
Are you regularly exposed to second-hand smoke or other potentially harmful substances at home or work? <input type="checkbox"/> YES <input type="checkbox"/> NO If so what? _____	Do you routinely need physical assistance with activities of daily living such as cooking, dressing, hygiene? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are guns kept in your home? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes is gun safety a priority at home? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does everyone in your home receive all routinely recommended immunizations? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is it important to you that you always wear your seatbelt? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have working smoke detectors in your home? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have regular problems with a lack of enough food in your home? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have regular problems with transportation? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have regular problems paying for housing? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you in an abusive relationship or afraid of physical harm from anyone you know? <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you at risk of acquiring HIV infection or other sexually transmitted disease? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do any members of your family have genetically linked health problems?
Do you use e-cigarettes, vape or juul? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Allergies - No Known Drug Allergies

Latex: Yes/No

Reconciled

Over the past two weeks, how often have you been bothered by any of the following? (Check Box)

	Not at All	Several Days	Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling depressed or hopeless	0	1	2	3

Wellness Screening History

	Date	Practice/Location Performed	Result
Wellness/Routine Physical Exam			
Colon Cancer Screening			
Mammogram			
Dexa (Bone Density) Scan			
Pap Smear			
PSA			
Full Body Skin Cancer Exam			
Hepatitis C Screening			
Diabetic Eye Exam			

If 65 years or older please answer the following:

Have you felt unsteady or fallen more than once in the past year?	Yes	No <input type="checkbox"/>
Can you switch a light on/off easily from your bed without fear of falling?	Yes	No <input type="checkbox"/>
Are floors and walkways in your home safe and in good repair?	Yes	No
Is it difficult to get out of bed or off a chair or toilet without assistance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the lighting in your home sufficient for you to see safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>