CHRISTOPHER V. FLORES, MD
A MEDICAL CORPORATION

Name of Patient: _____ _____ _____ (First) (MI) (Last)	**Date of Birth:** _____ **Gender:** ☐ Male ☐ Female
Local Address: _____ _____	**Can we mail confidential information to your local address?** ☐ Yes ☐ No
Permanent Address: _____ _____	**Can we mail confidential information to your permanent address?** ☐ Yes ☐ No
Name of Spouse/Significant Other: _____ **Can we share confidential information with your spouse/significant other:** ☐ Yes ☐ No	**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Other
Your Phone Number: Home: _____ Work: _____ Cell _____ Permanent Address Telephone Number : _____ **Where can we leave a confidential message?** *(Please check all that apply)* ☐Home ☐Work ☐Cell ☐ Permanent Address Telephone Number **Emergency Contact:** Name: _____ Relationship: _____ Phone Number: Home: _____ Work: _____ Cell _____ Address: _____	**PLEASE NOTE: We do not contract directly with any insurance (PPO, HMO, Medicare or Medi-Cal). If you are on Medicare, we will be asking you to sign a Medicare Private Contract. Please note that Medicare, Medi-Cal and HMOs will not allow you to seek reimbursement for our services.**

Insurance Information: Are you on Medicare Part B? ☐Yes ☐ No (We need insurance information to coordinate your care)

DR. FLORES HAS OPTED OUT OF MEDICARE & DOES NOT CONTRACT WITH ANY OTHER INSURANCE
IF YOU HAVE ANY QUESTIONS ABOUT WHAT THIS MEANS, PLEASE ASK DR. FLORES OR MARI

☐ PPO ☐ HMO ☐ Other: _____

Primary Coverage: Insurance Company: _____ ID#:_____

Secondary Coverage: Insurance Company: _____ ID#:_____

Subscriber Information: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ **Subscriber's Date of Birth**: _____
Name and Address of Subscriber: _____

Your Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown ☐ Prefer Not to Answer
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic nor Latino ☐ Other ☐ Prefer Not to Answer

How did You Hear about Dr. Flores? _____

List of Doctors/Health Providers: _____ _____ _____ _____	****FEMALES ONLY**** **Birth Control?** ☐ N/A _____

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List of Hospitalizations/Surgeries: _____
_____
_____
_____

Last Colonoscopy? _____ ☐ N/A **Next Colonoscopy due?** _____

Which PHARMACY do you like to use? _____

Allergies to any Medications? ☐ Yes ☐ No
Please list and describe reaction: _____
_____
_____
_____

List of Medications Currently Taking: _____
_____
_____
_____

List of Vitamins/Herbal Medications Currently Taking: _____
_____
_____
_____

Do You Consume?

Beer or Wine	☐Yes ☐ No ☐ Quit	How much per week? _____
Liquor	☐Yes ☐ No ☐ Quit	How much per week? _____
Tobacco Products	☐Yes ☐ No ☐ Quit	How much per week? _____
Marijuana	☐Yes ☐ No ☐ Quit	How much per week? _____
Other Drugs	☐Yes ☐ No ☐ Quit	How much per week? _____
Coffee/Coke/Caffeine	☐Yes ☐ No ☐ Quit	How much per week? _____

Do you feel like you have a problem with any of these substances? ☐Yes ☐ No
Explain: _____

Please put an X on the following scale as to where your comfort level is with respect to Traditional vs. Complementary/Alternative Medicine.

◄----------►
Traditional Medicine **Complementary/Alternative Medicine**

****FEMALES ONLY****

First Menstrual Period? ☐ N/A
_____

Last Menstrual Period? ☐ N/A
_____

Last Breast Exam? ☐ N/A
_____

Last Mammogram? ☐ N/A
_____

Last Pelvic Exam? ☐ N/A
_____

Last PAP? ☐ N/A
_____

Any abnormal PAPs? ☐ N/A
☐ Yes ☐ No When? _____

☐ N/A
No. of Pregnancies: _____

No. of Live Births: _____

Miscarriages: ☐Yes ☐ No

Irregular or Painful Periods?
☐Yes ☐ No

Vaginal Itch or Odor? ☐Yes ☐ No

Vaginal Dryness? ☐Yes ☐ No

Premenstrual Tension/Mood Swings? ☐Yes ☐ No

Problems with Urination/Bladder?
☐Yes ☐ No ☐

Medical History	**Personal? Family?**	**Symptoms**	**Personal?**
Alcoholism	☐ yes &/or ☐ family member	*Nosebleeds*	☐ yes
Allergies/Hay fever	☐ yes &/or ☐ family member	*Sinus Pains, Nasal Stuffiness*	☐ yes
Anemia	☐ yes &/or ☐ family member	*Frequent Sore Throat, Tonsillitis*	☐ yes
Arthritis/Rheumatism	☐ yes &/or ☐ family member	*Hoarseness*	☐ yes
Asthma	☐ yes &/or ☐ family member	*Swollen Glands (Lymph Nodes)*	☐ yes
Birth Defects	☐ yes &/or ☐ family member	*Shortness of Breath*	☐ yes
Bleeding Disorders	☐ yes &/or ☐ family member	*Frequent Coughs, Wheezing*	☐ yes

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Medical History	Personal? Family?	Symptoms	Personal?
Cancer or Tumor	□ yes &/or □ family member	*Palpitations, Chest Pain, Rapid Heartbeat*	□ yes
Colitis or Crohn's	□ yes &/or □ family member	*Anxious Feeling in Chest or Stomach*	□ yes
Congenital Heart Disease	□ yes &/or □ family member	*Poor Appetite*	□ yes
Depression	□ yes &/or □ family member	*Indigestion*	□ yes
Diabetes	□ yes &/or □ family member	*Abdominal Pain, Discomfort, Bloating*	□ yes
Emphysema, COPD	□ yes &/or □ family member	*Constipation, Use of Laxatives*	□ yes
Epilepsy, Seizures	□ yes &/or □ family member	*Diarrhea, Bloody Stools*	□ yes
Frequent Infections	□ yes &/or □ family member	*Rectal Pain, Itching, Irritation*	□ yes
Genetic Disease	□ yes &/or □ family member	*Hemorrhoids, Anal Fissures*	□ yes
Glaucoma, Cataracts	□ yes &/or □ family member	*Difficulty Urinating*	□ yes
Gonorrhea/Chlamydia	□ yes &/or □ family member	*Urinary Incontinence*	□ yes
Gout	□ yes &/or □ family member	*Burning with Urination*	□ yes
Herpes	□ yes &/or □ family member	*Frequent Urination*	□ yes
Heart Disease/Heart Attacks	□ yes &/or □ family member	*Breast Pain or Discharge*	□ yes
High Blood Pressure	□ yes &/or □ family member	*Breast Lumps*	□ yes
HIV/AIDS	□ yes &/or □ family member	*Pain with Intercourse*	□ yes
Infertility	□ yes &/or □ family member	*Swollen or Painful Legs*	□ yes
Kidney Disease	□ yes &/or □ family member	*Back Pain. Sciatica*	□ yes
Liver Disease, Hepatitis	□ yes &/or □ family member	*Joint Pain, Joint Swelling*	□ yes
Mental Illness	□ yes &/or □ family member	*Skin Discoloration, Rashes, Sores, Moles*	□ yes
Migraine Headaches	□ yes &/or □ family member	*Severe Perspiration, Night Sweats*	□ yes
Nervous Breakdown	□ yes &/or □ family member	*Nightmares, Recurrent Dreams*	□ yes
Obesity	□ yes &/or □ family member	*Fears or Phobias*	□ yes
Osteoporosis	□ yes &/or □ family member	*Anxiety or Nervousness*	□ yes
Peptic Ulcer Disease	□ yes &/or □ family member	*Angry, Irritable, Impatient, Critical*	□ yes
Pelvic Inflammatory Disease	□ yes &/or □ family member	*Sadness, Grief, Depression*	□ yes
Prostrate Problems	□ yes &/or □ family member	*Hearing Loss, Ringing in Ears*	□ yes
Psoriasis, Eczema	□ yes &/or □ family member	*Ear Pain or Drainage*	□ yes
Rheumatic Fever	□ yes &/or □ family member	*Vision Disturbance*	□ yes
Stroke	□ yes &/or □ family member	*Men: Difficulty with Erection(s)*	□ yes
Attempted Suicide	□ yes &/or □ family member	*Men: Penis or Testicle Problem*	□ yes
Thyroid Disease	□ yes &/or □ family member	*Frequent Headaches*	□ yes
Tuberculosis	□ yes &/or □ family member	*Loss of Memory*	□ yes
	□ yes &/or □ family member	*General Weakness/Loss of Energy*	□ yes
		Dizzy Spells, Fainting Spells or Blackouts	□ yes

By signing below, I acknowledge that the information provided is true and correct to the best of my knowledge.

Your Name: _____ Date: _____

Your Signature: _____