



Family Medicine Associates
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Welcome to Family Medicine Associates!

Our practice features a team of 3 Family Physicians, 2 Nurses and a Physician Assistant.

We are dedicated to serving the health care needs of our patients. Family Medicine/Primary Care is the medical specialty devoted to the comprehensive health care of you and your family ages 18 and above.

Our mission is to help you achieve optimal health through healthy lifestyle and disease prevention.

We provide high quality, compassionate care through open communication and respect for your concerns.

Here at Family Medicine Associates, we are committed to medical education, and our office is an active training site for medical schools, residency programs and physician assistant schools. While students are a part of the health care team, you may always decline to be seen by a student.

Please complete the documents in this new patient packet and bring them with you to your appointment. We look forward to meeting you!



PATIENT INFORMATION

(Please Print) Today's Date: _____

PATIENT NAME:										
DATE OF BIRTH:		SEX:	MALE	FEMALE	OTHER	SSN:				
PATIENT ADDRESS:				CITY:			STATE:		ZIP:	
(Please check the box to indicate your preferred means of communication)										
HOME PHONE:					WORK PHONE:					
CELL PHONE:					EMAIL:					
EMPLOYER:					MARITAL STATUS:					
RACE:	AMERICAN INDIAN/ALASKA NATIVE			BLACK/AFRICAN AMERICAN			WHITE/CAUCASIAN		ASIAN	
	HAWAIIAN/PACIFIC ISLANDER			OTHER			DECLINED		UNKNOWN	
ETHNICITY:	NOT HISPANIC OR LATINO			HISPANIC OR LATINO			DECLINED		UNKNOWN	
LANGUAGE:					INTERPRETER NEEDED:					
SPOUSE'S NAME:					SPOUSE'S DATE OF BIRTH:					
EMERGENCY CONTACT:					RELATIONSHIP TO PATIENT:					
HOME PHONE:					OTHER PHONE:					
PRIMARY CARE PHYSICIAN:					REFERRING PHYSICIAN:					

INSURANCE INFORMATION

(Please present insurance card to receptionist upon check-in)

PRIMARY INSURANCE INFORMATION PLAN NAME:										
POLICY HOLDER:					EFFECTIVE DATE:					
INSURANCE ID #:				GROUP#:			PLAN #:			
SECONDARY INSURANCE INFORMATION PLAN NAME:										
POLICY HOLDER:					EFFECTIVE DATE:					
INSURANCE ID #:				GROUP#:			PLAN #:			
OTHER INSURANCE INFORMATION PLAN NAME:										
POLICY HOLDER:					EFFECTIVE DATE:					
INSURANCE ID #:				GROUP#:			PLAN #:			

ASSIGNMENT AND RELEASE OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Family Medicine Associates** or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date



Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	M	F	DOB:
Marital status:	Single	Partnered	Married
	Separated	Divorced	Widowed
Previous or referring doctor:	Date of last physical exam:		

PERSONAL HEALTH HISTORY

Childhood illness:	Measles	Mumps	Rubella	Chickenpox	Rheumatic Fever	Polio
Immunizations and dates:	Tetanus			Pneumonia		
	Hepatitis			Chickenpox		
	Influenza			MMR <i>Measles, Mumps, Rubella</i>		

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	Sedentary (No exercise)				
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			Yes	No
	If yes, are you on a physician prescribed medical diet?			Yes	No
	# of meals you eat in an average day?				
	Rank salt intake	High	Med	Low	
	Rank fat intake	High	Med	Low	
Caffeine	None	Coffee	Tea	Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			Yes	No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			Yes	No
	Have you considered stopping?			Yes	No
	Have you ever experienced blackouts?			Yes	No
	Are you prone to "binge" drinking?			Yes	No
	Do you drive after drinking?			Yes	No
Tobacco	Do you use tobacco?			Yes	No
	Cigarettes – pks./day	Chew-#/day	Pipe-#/day	Cigars-#/day	
	# of years	Or year quit			
Drugs	Do you currently use recreational or street drugs?			Yes	No

	Have you ever given yourself street drugs with a needle?	Yes	No
Sex	Are you sexually active?	Yes	No
Personal Safety	Do you live alone?	Yes	No
	Do you have frequent falls?	Yes	No
	Do you have vision or hearing loss?	Yes	No
	Do you have an Advance Directive or Living Will?	Yes	No
	Would you like information on the preparation of these?	Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	Yes	No
Seatbelt Use	Do you wear your seatbelt while driving?	Yes	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	M	
				F	
Mother				M	
				F	
Sibling	M			M	
	F			F	
	M		M		
	F		F		
	M		Grandmother <i>Maternal</i>		
	F		Grandfather <i>Maternal</i>		
M		Grandmother <i>Paternal</i>			
F		Grandfather <i>Paternal</i>			

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY

Number of pregnancies ____ Number of live births ____

Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	Yes	No
If yes, # of times ____		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam?	Yes	No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	