Lovelace Medical Group

Patient Information

Legal Name: Last	First:	☐ Female	☐ Male
Email Address:		DOB:	

Preferred Local Pharmacy

Name:_____

Location:_____

Phone:_____

Fax:_____

Mail-In Pharmacy

☐ Medco

☐ Express Scripts

☐ RightSource

☐ Other_____

☐ Prime Mail

☐ Prescription Soultions

☐ CVS/Caremark

End-Of-Life Planning

When you visit Lovelace Medical Group you have the right under New Mexico state law to make decisions about the care you receive. You have the right to accept or refuse any treatment or procedure that your provider recommends to you. Your provider will prescribe a treatment plan for you and discuss their recommendations with you. You should ask for additional information concerning anything that you do not understand completely. Lovelace Medical Group recommends that you tell us who should make decisions regarding your care if you become unable to make those decisions yourself. Usually, this is your spouse or a family member who knows your wishes, but it can be another individual who knows you best.

1. Do you have a "Living Will" or Advanced Directive for Health Care? ☐ Yes ☐ No

   If not, would you like to receive a copy or have help completing one? ☐ Yes ☐ No

2. Do you have a "Power of Attorney"? ☐ Yes ☐ No

   If "Yes", please list their name:_____ Relationship to you: _____

3. Have you designated a person that you want to make health care decisions on your behalf if you become physically or mentally unable to do so?

   If "Yes", please list their name:_____ Relationship to you: _____

I understand that I am not required to have an Advanced Directive for Healthcare in order to receive treatment. I also understand that if I do not appoint a healthcare proxy, my family's rights may be limited under New Mexico law. I have been given the explanation of my rights to accept or refuse medical treatment and formulate and Advanced Directive.

Medications *(List all current medications including over the counter)*

☐ NO Current Medications

Medication Name	Dosage Strength (i.e.,mg/mcg)	How many times a day?
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Allergies

☐ Check box if ther are NO medication allergies.

Drug Name/ Drug Class/ Food	Reaction
1	
2	
3	
4	
5	
6	
7	
8	
9	

Past Medical History

Check all that apply.

- ☐ Abnormal PAP
- ☐ Allergies
- ☐ Anemia
- ☐ Anesthesia reaction
- ☐ Angina (heart pain)
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Blood clots
- ☐ Bronchitis
- ☐ Cancer
- ☐ COPD
- ☐ Coronary artery
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated lipids
- ☐ Headache/migraine
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Irratable bowel
- ☐ Kidney disease
- ☐ Mental disorder
- ☐ Myocardial
- ☐ Osteoporosis
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Thyroid

Past Surgical History

Check all that apply. Describe details of medical conditions in spaces below.

	Year		Year		Year		Year
☐ Appendectomy	_____	☐ Gastric bypass	_____	☐ Small bowel surgery	_____	☐ Hysterectomy	_____
☐ Angioplasty	_____	☐ Groin hernia repair	_____	☐ Thyroid surgery	_____	☐ Mastectomy	_____
☐ Arthroscopy knee	_____	☐ Hip replacement	_____	☐ Tonsillectomy	_____	☐ Breast Reduction	_____
☐ Back surgery	_____	☐ Knee replacement	_____	☐ Breast implants	_____	☐ Overies Removed	_____
☐ Carpal tunnel	_____	☐ LASIK	_____	☐ Breast biopsy	_____	☐ Vasectomy	_____
☐ Cataract	_____	☐ Liver diopsy	_____	☐ Tubes tied	_____	☐ Prostate biopsy	_____
☐ Gallbladder	_____	☐ Hip racture repair	_____	☐ C-Section	_____	☐ TRUP	_____
☐ Colon surgery	_____	☐ Pacemaker	_____	☐ D&C	_____		

☐ Other _____

_____

Preventive Care

List the dates of the most recent preventive services you've received.

Test	Performed		Date Preformed
Colonoscopy	☐ Yes	☐ No	_____
Bone density test	☐ Yes	☐ No	_____
Glaucoma test	☐ Yes	☐ No	_____
HIV test	☐ Yes	☐ No	_____
Abdominal aortic aneurysm test	☐ Yes	☐ No	_____
Hearing test	☐ Yes	☐ No	_____
Vision test	☐ Yes	☐ No	_____
Prostate exam (males only)	☐ Yes	☐ No	_____
PSA (prostate cancer blood test)	☐ Yes	☐ No	_____
Contraceptive	☐ Yes	☐ No	_____
Mammogram	☐ Yes	☐ No	_____

Family History

Diagnosis	Circle one	Family Member	Diagnosis	Circle one	Family Member
Alcoholism	No Yes		Gallbladder disease	No Yes	
Alzheimer's disease	No Yes		Hyperlipidemia	No Yes	
Asthma	No Yes		Irritable bowel synd.	No Yes	
Blood disorders	No Yes		Liver disease	No Yes	
CAD	No Yes		Migraines	No Yes	
Cancer (type):	No Yes		Obesity	No Yes	
Cardiac disease	No Yes		Osteoporosis	No Yes	
Colitis	No Yes		Peptic ulcer disease	No Yes	
Colon cancer	No Yes		Renal disease	No Yes	
Colon polyps	No Yes		Rheumatoid arthritis	No Yes	
Crohn's disease	No Yes		Seizure disorder	No Yes	
CVA	No Yes		Ulcerative colitis	No Yes	
Diabetes	No Yes		Other:	No Yes	
Diverticular disease	No Yes		Other:	No Yes	

Social History

Your answers may help determine your risk for certain diseases. Responses are confidential.

Have you been a victim of… ☐ Physical Abuse ☐ Sexual Abuse

Comments_____

Tobacco Use

Do you… ☐ Smoke a pipe ☐ Chew Tobacco ☐ Smoke Cigarettes ☐ E-sig

How many…

Packs per day? _____

Years? _____

If you quit, what year? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type? _____

If yes, how much? _____

If yes, how often? ☐ Daily ☐ Monthly ☐ Weekly ☐ Occasionally ☐ Rarely

Do you use Illegal drugs? ☐ Yes ☐ No

If yes, what type? _____

If yes, how much? _____

If yes, how often? ☐ Daily ☐ Monthly ☐ Weekly ☐ Occasionally ☐ Rarely

Are you currently pregnant: ☐ Yes ☐ No