



Please return completed form by email or fax:
Email: info@mysymbios.com
Fax: 843-738-4801

Date: _____

Patient Information

Patient Name (Last) _____ (First) _____ (MI) _____

Preferred Name: _____ Date of Birth _____ Social Security Number _____

Sex _____ Marital Status: _____ Patient Email: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Race (Check One)

African American/Black

American Indian

Alaska Native

Asian Native Hawaiian/Pacific Islander

White

Other

Ethnicity (Circle One)

Hispanic or Latino

Not Hispanic or Latino

Occupation: _____ Employer: _____

Emergency Contact Full Name: _____ Phone: _____

Primary

Insurance: _____ Policy# _____

Group: _____ Subscriber: _____ DOB: _____

Secondary Insurance: _____ Policy# _____

Group: _____ Subscriber: _____ DOB: _____

PATIENT COMMUNICATION **PREFERENCES**

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers. You will be asked several questions that fall into HIPAA, please answer them to help us protect your privacy.

Do you authorize this office to mail correspondence to the address you have on file? YES ☐ NO ☐

Do you authorize this office to leave voice mail messages (Home answering machine/Cell phone) regarding your medical conditions, test results, medications, and appointments? YES ☐ NO ☐

Do you authorize this office to send text/SMS messages regarding your medical conditions, test results, medications, and appointments? YES ☐ NO ☐

Do you authorize this office to send emails regarding your medical conditions, test results, medications, and appointments? YES ☐ NO ☐

Do you want to use the immunization registry? YES ☐ NO ☐

Do you want to participate in immunization info sharing? YES ☐ NO ☐

Do you want to participate in health info exchange? YES ☐ NO ☐

Tobacco:

Do you currently use tobacco ? Did you use tobacco in the past ? How long: _____
☐ Yes ☐ No ☐ Yes ☐ No

☐ Cigarettes ____/day ☐ Chew ____/day ☐ Cigars ____/day

Alcohol Intake:

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Caffeine:

☐ None ☐ Occasional ☐ Moderate ☐ Heavy
cups/cans per day ? _____

Drugs:

Do you currently use recreation or street drugs ? ☐ Yes ☐ No

Are you sexually active ? ☐ Yes ☐ No

Are you interested in being screened for STD's ? ☐ Yes ☐ No

Advanced Directive:

Do you have and Advanced Directive or Healthcare Proxy? ☐ Yes ☐ No

Colonoscopy or Cologuard: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date: _____ Last Mammogram Date: _____

Date of last menstrual period or menopause: _____ Bone Density: _____

Number of pregnancies: ____ Number of Births: ____

Vaccines:

Pneumonia: _____ Flu: _____ Covid: _____ TDAP: _____

Other: _____

PAST MEDICAL HISTORY

Have you ever been told you had one of the following? Please check Yes if have now or have had in the past.

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	Diabetes Mellitus Type 1	☐	☐	Lung Disease	☐	☐
Anemia	☐	☐	Diabetes Mellitus Type 2	☐	☐	Mental Illness	☐	☐
Anxiety	☐	☐	Diabetic Complications	☐	☐	Movement Disorder	☐	☐
Arthritis	☐	☐	Endocrine Disease	☐	☐	Nerve Disease	☐	☐
Asthma	☐	☐	Eye Problems	☐	☐	Osteopenia/Osteoporosis	☐	☐
Autoimmune Disease	☐	☐	Gastritis/Ulcer	☐	☐	Overweight/Obesity	☐	☐
Back/Neck Pain	☐	☐	GERD/Acid Reflux	☐	☐	Pneumonia	☐	☐
Blood Disorder	☐	☐	Headaches/Migraine	☐	☐	Prostate Disorder	☐	☐
Bowel Disease	☐	☐	Hearing Loss	☐	☐	Spine Disease	☐	☐
CAD	☐	☐	Heart Rhythm Disorder	☐	☐	Stroke/TIA	☐	☐
CHF	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
COPD	☐	☐	Hypertension	☐	☐	Tuberculosis/Pos PPD	☐	☐
Cancer	☐	☐	Hyperlipidemia	☐	☐	Urinary Problems	☐	☐
Dementia	☐	☐	Kidney Disease/Stones	☐	☐	Viral Disease	☐	☐
Developmental	☐	☐	Liver	☐	☐	Other:		
Depression	☐	☐						

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	SIGNIFICANT HEALTH PROBLEMS
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Phone_____

Phone_____

MEDICATIONS

Direction

[illegible]