

Kevin Parzych M.D.

Richard David Griffith M.D.

Wilshire Connected Care, Inc.

Kevin Parzych, M.D.  
Ryan Hubbard, DO

Jeff Bariel, PA-C

Karen Chestnut, FNP

Patient Intake Form

Name (Last, First, Middle Initial):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: (Circle One) Male Female

Preferred Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Primary Care Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List all Vaccinations

|  |  |
| --- | --- |
| Vaccination: | Year: |
|  |  |
|  |  |
|  |  |

Please list all active treating physicians (i.e. pulmonologist, oncologist, cardiologist, etc.)

|  |  |
| --- | --- |
| Doctor’s Name: | Specialty: |
|  |  |
|  |  |
|  |  |

Ethnicity:

* + - Decline Response
    - Hispanic or Latino
    - Not Hispanic or Latino

Race:

* + - Decline Response
    - American-Indian or Alaska Native
    - Asian
    - Black or African American
    - Native Hawaiian or Pacific Islander
    - Caucasian
    - Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all past surgeries and hospitalizations and approximate date

|  |  |
| --- | --- |
| Procedure/Hospitalization: | Date: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Please list all current medications including OTC, supplements, etc.

|  |  |  |
| --- | --- | --- |
| Medication: | Dose: | Frequency: |
|  |  |  |
|  |  |  |
|  |  |  |

Please list any allergies to medications or other substances ( food, pets, etc.) and reactions ( rash, hives, anaphylaxis,etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Have you ever had any of the following: | Yes | No |
| Asthma/Breathing Problems |  |  |
| Arthritis |  |  |
| Bleeding/Clotting Problems |  |  |
| Blood Pressure Problems |  |  |
| Blood Transfusion |  |  |
| Bowel/Stomach Problems |  |  |
| Cancer |  |  |
| Cholesterol Problems |  |  |
| Diabetes |  |  |
| Eye Issues (Glaucoma, Cataract) |  |  |
| Gynecological Issues |  |  |
| Heart Disease/Disorder |  |  |
| Lung Disorder |  |  |
| Liver Disease |  |  |
| Neurological Disorder/Chronic Headaches |  |  |
| Psychiatric Disorder/Illness |  |  |
| Pulmonary Embolism/DVT |  |  |
| Stroke |  |  |
| Seizure/Epilepsy |  |  |
| Thyroid Disorder |  |  |
| Urinary/Kidney Disorder |  |  |

Please indicate any major conditions/illnesses that your immediate family members have had

|  |  |
| --- | --- |
| Relative: | Condition and Description: |
|  |  |
|  |  |
|  |  |
|  |  |

Smoking Status:

* + I am a current smoker, I smoke \_\_\_packs/day for the past \_\_\_years
  + I am currently not a smoker. I have smoked in the past, \_\_\_packs/day for \_\_\_years
  + I have never smoked

Alcohol Consumption:

* + Yes. How many drinks and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + No.

**I have completed and agree with the above:**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

277 South Street Ste S San Luis Obispo, CA 93401 Tel (800) 870-5920 Fax (805) 927-2973

Practices managed by Wilshire Health & Community Services, Inc.