DELAWARE FAMILY MEDICINE

Providing Excellent Medical Care For Your Family

Galicano Inguito, Jr., MD, MBA

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www.delawarefamilymedicine.com

Name:_____Date of Birth:_____/_____/_____

Address:_____City/ State:_____ Zip:_____

SSN:_____-_____-_____ Race: _____ Ethnicity:_____

Phone #: Home: _____ Cell:_____Birth Sex: ☐ Male ☐ Female

Email Address: _____

Emergency Contact Information

Name of Emergency Contact: _____

Relationship to you: _____Emergency Contacts Number: _____

Allergies: ☐ No Known Allergies ☐ Yes, please list all Drug, Food, & Environmental allergies

_____

_____

Medications: ☐ **I do not take any medications**

List all current Over the Counter and Prescribed Medications with their corresponding dosages (If known)

_____

_____

_____

****Please list one Pharmacy for all your medications, any change of pharmacy may delay the refill of the medications:**

Name of Pharmacy: _____ Phone Number: _____

***Due to Changes to Opioid Prescribing Regulations, in 01/2017. The regulations contain new requirements related to prescribing opiates for acute episodes as well as for chronic, long term pain management. Some components are at the discretion of the prescribing provider while other requirements are situation-based**. **Drug test can be administered at least every six months or at the doctor's discretion.** If you would like more information on the new changes, just ask the Front desk.

Please Initial_____

Personal Medical History:

☐ No Known Problems ☐ Yes. If so, Please list all current & past medical problems.

_____

_____

_____

Procedures & Surgeries:

☐ None ☐ Yes (**If so, please add dates.** Ex: Tonsillectomy,2005)

_____

_____

_____

Family History

☐ Negative ☐ Unknown ☐ Adopted

Type	Mother	Father	Sister	Brother	Grandmother Maternal	Grandmother Paternal	Grandfather Maternal	Grandfather Paternal
Alzhelmer's								
Arthritis								
Cancer								
Diabetes								
Heart Disease								
High Cholesterol								
Hypertension								
Kidney Disease								
Mental Illness								
Osteoporosis								
Seizures								
Thyroid Disease								
OTHER:								

Alcohol Use: Please circle if applicable: Beer | Wine | Liquor ☐ Past ☐ Never

Tobacco Use: Please circle if applicable: Cigarettes| Cigars | Oral | Pipe | Snuff ☐ Past ☐ Never

****If Yes, How many a day?** _____

Substance Abuse: Please specify the type: _____ ☐ Current ☐ Past ☐ Never

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Exercise/Physical Activity: Times per week: _____ specify: _____

Duration: _____