Two Spirit health services, inc.

Name: _____ **DOB:** _____

Preferred Name: _____

Address: _____

_____

Telephone Number: _____ **Email:** _____

Primary Care Physician: _____

Health Insurance Carrier: _____

Member ID #: _____ **Group#:** _____

Drug Allergies or Sensitivities:

List of Medications both prescribed or non-prescribed: (PLEASE INCLUDE DOSE AND FREQUENCY)

Have you ever been diagnosed or told you have any of the following? Please circle:

Diabetes	Yes	No	Cancer	Yes	No
High blood pressure	Yes	No	Nervous disorder	Yes	No
Heart Disease	Yes	No	Depression	Yes	No
Seizures or epilepsy	Yes	No	Arthritis	Yes	No
Hepatitis	Yes	No	HIV	Yes	No
Lung disorder	Yes	No	Anxiety	Yes	No
Kidney disorder	Yes	No	Other? Please list	Yes	No
Blood disorder	Yes	No		Yes	No

Do you do any of the following?

Drink Alcohol	Yes	No	Socially
Smoke	Yes	No	Socially
Recreational Drug use	Yes	No	Socially

Any vision or hearing loss? (describe): _____

Any life threatening conditions? (describe): _____

Have you been recently hospitalized? If so, please describe: _____

_____

Have you had any surgeries in the past 5 years? If so, please describe: _____

_____

Date of last physical? _____

Family Medical History: Anyone in the family with a history of any of the following? (please list who)

Diabetes	Thyroid condition	Mental Illness
High blood pressure	Lung condition	Other
Heart disease	Kidney disease	
Arthritis	Epilepsy	
Depression	Cancer	

_____

_____

Any other specific medical information: _____

Please list a pharmacy you would like us to put on file for you: (if we need to send prescriptions)

Name of Pharmacy: _____

Location(address): _____ **Phone #:** _____