New Patient Check-In Form

Patient Name ___________________ Date of Birth ___________________	**For Internal Use Only** Height _____ Weight ________ Blood Pressure __________ Pulse __________ Temp ________ Resp _____________

Guardian / Support Role (if appropriate)
Name ________________________ Relationship ______________________
Role: ___Next of Kin ___ Guardian ___Caregiver

Please provide as much detail as you are able so that we can give you the safest and best care possible.

What is the primary reason for your visit? ____

MEDICATIONS

Please list any medications you are taking, with dose and frequency.

Medication	Dosage	# per Day	Do you need refills?
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____
____________________________________	____________	________	Yes____

Please list Vitamins, Supplements and Over the Counter Medicines

____

____

Please provide your preferred pharmacy name and location

____

____

DO NOT RETAIN THIS AS PART OF THE PERMANENT MEDICAL RECORD

ALLERGIES

Please list any allergies and intolerances to **medications**

Allergy	**Reaction**
____	______________________________
____	______________________________
____	______________________________

Do you have an Egg, Neomycin or Gelatin allergy? No___ Yes____

Do you have an allergy to intravenous contrast? No___ Yes____

Please list any allergies to **food** or the **environment**

Allergy	**Reaction**
____	______________________________
____	______________________________
____	______________________________

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

__Allergies	__Blood Clots	__Gallbladder Disease	__Heart Attack
__Anemia	__Cancer (type)________	__GERD – Reflux	__Osteoarthritis
__Angina	__Stroke	__Hepatitis C	__Ulcers
__Anxiety	__COPD	__High Cholesterol	__Kidney Disease
__Arthritis	__Heart Disease	__Hypertension	__Seizure Disorder
__Asthma	__Crohn's Disease	__Irritable Bowel	__Thyroid Disease
__Atrial Fibrillation	__Depression	__Liver Disease	
__Prostate Enlargement	__Diabetes	__Migraines	

Other medical problems:

____

____

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SURGICAL HISTORY

What **surgeries** have you had? Please mark **all** that apply and include the year they were performed.

__Angioplasty________ __Gastric Bypass________

__Angio w/Stent__________ __Hernia Repair________

__Appendectomy__________ __Knee Replacement________

__Arthroscopic Knee_________ __LASIK________

__Back Surgery__________ __Liver Biopsy________

__Heart Bypass__________ __Pacemaker___________

__Carpal Tunnel__________ __Bowel Resection________

__Cataract Extraction__________ __Thyroidectomy________

__Gallbladder Removal________ __Tonsillectomy________

Men Only:

__Prostate Biopsy________ __Transurethral Resection_________ __Vasectomy________

Women Only:

__Augmentation Mammoplasty________ __Mastectomy________

__Bilateral Tubal Ligation_________ __Myomectomy_________

__Breast Biopsy________ __ Reduction Mammoplasty ________

__Cesarean Section________ __TAH/BSO________

__Dilation and Curettage _________ __Vaginal Hysterectomy_________

__Hysterectomy________

Other surgeries:

____

Have you had any recent hospitalizations or ER visits?

____

____

FAMILY HISTORY

Mother ___Alive ___Deceased (age at death)_______ Cause of Death ___________________

Medical problems ____

Father ___Alive ___Deceased (age at death)_______ Cause of Death _______________

Medical problems ____

Siblings Number of Brothers____ Number of Sisters ____ Medical problems __________________________

Children Number of Sons ____ Number of Daughters ____ Medical problems __________________________

Have any of the women in your family had a heart attack/heart disease at age 65 or younger? No___ Yes ___

Have any of the men in your family had a heart attack/heart disease at age 55 or younger? No___ Yes ___

Any additional pertinent family history:

____

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SOCIAL HISTORY

Marital Status ____________ Occupation _______________________ Employer __________________________
Exercise? No___ Yes ___ Type ____________________ Hours per Week ______________________

How many people other than you reside in your household? ___Spouse ___Children ___Grandparents ___Other
Do you have advance directives? ____________________________________
Do you have any religious belief that could affect your medical care? ____________________________________

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Please check your current tobacco status. ( ) Current ( ) Never ( ) Former

Do you use Alcohol? No ___ Yes___ Type _________________ Amount _________ Frequency__________
Do you use Caffeine? No ___ Yes___ Type _________________ Amount _________ Frequency__________
Do you use Illicit Drugs? No ___ Yes___ Type _________________ Amount _________ Frequency__________

OTHER

Do you use contraceptives? No ___ Yes___ Type _______________________________
Who is your dentist? _____________________________ Telephone ______________________
Do you have any dental / oral problems? ____

RECENT HISTORY

Males & Females

Last Colonoscopy Date: ________ Normal?: No____ Yes____
Last Cholesterol Date: ________ Normal?: No____ Yes____

Males Only

Last PSA Date ____________ Normal?: No____ Yes____

Females Only

Last Pap Date ________ Normal?: No____ Yes____ History of Abnormal Pap? No____ Yes____
Last Bone Density Date ________ Normal?: No____ Yes____ # of Pregnancies _____
Last Mammogram Date ________ Normal?: No____ Yes____ # of Births _____

In past 2 weeks, have you had little interest or pleasure in doing things?

Not at all (0)_____ Several days(1)_____ More than half the days(2)____ Nearly every day(3)_____

In past 2 weeks, have you been feeling down, depressed or hopeless?

Not at all (0)_____ Several days(1)_____ More than half the days(2)____ Nearly every day(3)_____

Please list your most recent Healthcare Provider(s) ____

How did you hear about us? ____

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