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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