PATIENT INFORMATION

PLEASE PRINT

Date_____

Patient Name_____

Address_____

Home Phone#_____ Cell Phone #_____

Email address _____

Preferred Communication: ____Home Phone _____Cell _____Email

Date of Birth_____ SS#_____

Marital Status_____ Race_____

Insurance company_____ID #_____Group #_____

Primary Insured Name_____ DOB_____

Relationship to Patient: _____self _____spouse _____parent

_____ other (specify)_____

Primary Doctor_____

Referring Doctor_____

Preferred Pharmacy_____

NEW PATIENT FORM

Name: _____ Date of Birth ____/____/____

Preferred Contact Number:

1. Medical Problems (high blood pressure, diabetes, high cholesterol, asthma, etc):

_____
_____
_____
_____
_____
_____

2. Past Surgeries / Year performed:

_____
_____
_____

3. Medications: Name, Strength, Instructions

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Family History: Please list any diseases that run in the family, specifically those listed below. Please also list relationship of affected persons to you:

Coronary Artery Disease (Heart Attacks), Cancer (and type), Diabetes, Kidney Disease, Stroke

_____
_____
_____

5. Drug or Food Allergies

_____ REACTION: _____
_____ REACTION: _____
_____ REACTION: _____

6. Do you:

Smoke? YES / NO Packs per day?_____ Age Started?_____ If Quit, Age?_____

Drink Alcohol? YES / NO How Often? ☐ Daily ☐ Weekly ☐ Rare/Socially

Type / Amount?_____

7. Personal Information (optional)

Married / Single / Divorced / Widowed

Occupation:_____ Education:_____

Hobbies:_____

Spouse (if applicable):_____ Spouse's Occupation:_____

Children (ages):_____

_____

8. When was your last (if applicable):

Colonoscopy _____ NORMAL / ABNORMAL

Males: Prostate Exam _____ NORMAL / ABNORMAL

Females: Pap Smear_____ NORMAL / ABNORMAL

Mammogram_____ NORMAL / ABNORMAL

9. Do you suffer from (circle all that apply):

Chest pains	Snoring	Shortness of Breath	Abdominal Pain	Frequent Urination
Depression	Fatigue	Joint or Muscle pains	Chronic cough	Unexplained weight loss
Nausea/Vomiting		Blood in Stools	Other_____	

10. Have you been followed by a specialist in the last 5 years (Dermatologist, Gastroenterologist, Pulmonologist, Cardiologist, Gynecologist, Neurologist, etc.)? Please list each one and what you were seen for:

11. Preferred Pharmacy: _____

12. Use the following space if unable to fit answers into provided areas above.