



This section for office use.

New patient  Established patient

Patient Information

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Marital Status:  Married  Single

Social Security Number: \_\_\_ - \_\_\_ - \_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  Divorced  Widowed  Other: \_\_\_

Advance Directives

Date Reviewed: \_\_\_  None  DNR  Living Will  Durable Power of Attorney  HC Proxy

Medications

List all medications you take, prescription and non-prescription (vitamins, over the counter meds, herbals, etc.) and their dosage:

No medications

Table with 2 columns: Medication, Dose. Rows 1-8.

(Attach additional pages as necessary)

Allergies

No known allergies

Table with 2 columns: Allergy, Reaction. Rows 1-8.

Reason for today's visit (please list any symptoms that you would like to discuss with your doctor):

Blank lines for writing symptoms.

Patient name: \_\_\_\_\_ M.R. # \_\_\_\_\_

### Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

<input type="checkbox"/> Alcohol addiction	___/___/___	<input type="checkbox"/> Emphysema	___/___/___	<input type="checkbox"/> Migraines	___/___/___
<input type="checkbox"/> Allergies	___/___/___	<input type="checkbox"/> Esophageal reflux	___/___/___	<input type="checkbox"/> Obesity	___/___/___
<input type="checkbox"/> Anemia	___/___/___	<input type="checkbox"/> Gallbladder stones	___/___/___	<input type="checkbox"/> Osteoporosis	___/___/___
<input type="checkbox"/> Anxiety	___/___/___	<input type="checkbox"/> Heart Disease	___/___/___	<input type="checkbox"/> Rheumatoid Arthritis	___/___/___
<input type="checkbox"/> Asthma	___/___/___	<input type="checkbox"/> Liver Disease	___/___/___	<input type="checkbox"/> Seizures/epilepsy	___/___/___
<input type="checkbox"/> Blood clots	___/___/___	<input type="checkbox"/> Other heart problems	___/___/___	<input type="checkbox"/> Sleep apnea	___/___/___
<input type="checkbox"/> Cancer	___/___/___	Type: _____		<input type="checkbox"/> Stomach ulcer	___/___/___
Type: _____		<input type="checkbox"/> Heart failure	___/___/___	<input type="checkbox"/> Stroke (CVA)	___/___/___
<input type="checkbox"/> Chronic bronchitis	___/___/___	<input type="checkbox"/> Hepatitis	___/___/___	<input type="checkbox"/> Tuberculosis	___/___/___
<input type="checkbox"/> Circulatory disease	___/___/___	<input type="checkbox"/> High blood pressure	___/___/___	<input type="checkbox"/> Thyroid disease	___/___/___
<input type="checkbox"/> COPD	___/___/___	<input type="checkbox"/> High cholesterol	___/___/___	Type: _____	
<input type="checkbox"/> Crohn's Disease	___/___/___	<input type="checkbox"/> Irritable bowel syndrome	___/___/___	<input type="checkbox"/> Other:	___/___/___
<input type="checkbox"/> Depression	___/___/___	<input type="checkbox"/> Kidney Stones	___/___/___	_____	
<input type="checkbox"/> Diabetes Type I	___/___/___	<input type="checkbox"/> Kidney Disease	___/___/___	<input type="checkbox"/> Other:	___/___/___
<input type="checkbox"/> Diabetes Type II	___/___/___	Type: _____		_____	

### Gynecological Medical History

Age of First Menstrual Cycle: \_\_\_\_\_

Birth control method: \_\_\_\_\_

Sexually Active  Current  Past  Never

Domestic Violence  Current  Past  Never

Period regular	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Endometriosis	___/___/___	<input type="checkbox"/> Ovarian Cyst	___/___/___
Period painful	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fibroids	___/___/___	<input type="checkbox"/> PCOS	___/___/___
Heavy periods	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> History of Gonorrhea	___/___/___	<input type="checkbox"/> Pelvic pain	___/___/___
<input type="checkbox"/> Genital Herpes	___/___/___	<input type="checkbox"/> History of Chlamydia	___/___/___	<input type="checkbox"/> Last Pap	___/___/___
<input type="checkbox"/> Pelvic inflammatory Disease	___/___/___	<input type="checkbox"/> Infertility	___/___/___	<input type="checkbox"/> Abnormal PAP Test	___/___/___

### Obstetric History (list pregnancies, miscarriages and abortions in order)

	Year	Type of Delivery	M or F	Weight	Complications
1					
2					
3					
4					
5					
6					

### Female Surgical History

Please check all that apply.

<input type="checkbox"/> Total Abdominal Hysterectomy with / Without Removal of Ovaries	Date _____	<input type="checkbox"/> Myomectomy	Date _____
<input type="checkbox"/> Vaginal Hysterectomy with / without Removal Of Ovaries	_____	<input type="checkbox"/> Reduction Mammoplasty	_____
<input type="checkbox"/> D and C (Dilation and Curettage)	_____	<input type="checkbox"/> Augmentation Mammoplasty	_____
<input type="checkbox"/> Cesarean Section	_____	<input type="checkbox"/> Mastectomy ___ Right ___ Left	_____
<input type="checkbox"/> Breast Biopsy	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> LEEP / Cone Biopsy	_____		
<input type="checkbox"/> Endometrial Ablation	_____		
<input type="checkbox"/> Bilateral Tubal Ligation / Other Sterilization	_____		

Patient name: \_\_\_\_\_ M.R. # \_\_\_\_\_

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### Surgical History

Please check all that apply.

<input type="checkbox"/> Angioplasty <input type="checkbox"/> Angioplasty w/ stent <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arthroscopy knee <input type="checkbox"/> Back surgery <input type="checkbox"/> Coronary Artery Bypass Graft <input type="checkbox"/> Carpal tunnel release <input type="checkbox"/> Cataract extraction <input type="checkbox"/> Other: _____	Date _____ <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Colectomy <input type="checkbox"/> Colostomy <input type="checkbox"/> Gastric bypass <input type="checkbox"/> Hernia repair <input type="checkbox"/> Hip replacement <input type="checkbox"/> Knee replacement <input type="checkbox"/> LASIK Date _____	Date _____ <input type="checkbox"/> Liver biopsy <input type="checkbox"/> Open Reduction Internal Fixation <input type="checkbox"/> Pacemaker <input type="checkbox"/> Small bowel resection <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy Date _____
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### Family History

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death.  Adopted

	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
<input type="checkbox"/> Alcoholism						
<input type="checkbox"/> Alzheimer's disease						
<input type="checkbox"/> Blood Disease						
<input type="checkbox"/> Heart Disease						
<input type="checkbox"/> Heart Disease Before 50						
<input type="checkbox"/> Cancer						
Type: _____						
_____						
<input type="checkbox"/> Depression						
<input type="checkbox"/> Developmental delay						
<input type="checkbox"/> Diabetes						
<input type="checkbox"/> Hearing deficiency						
<input type="checkbox"/> High cholesterol						
<input type="checkbox"/> Hypertension						
<input type="checkbox"/> Kidney disease						
<input type="checkbox"/> Mental illness						
<input type="checkbox"/> Migraines						
<input type="checkbox"/> Obesity						
<input type="checkbox"/> Osteoporosis						
<input type="checkbox"/> Seizures/epilepsy						
<input type="checkbox"/> Stroke (CVA)						
<input type="checkbox"/> Other:						
<input type="checkbox"/> Other:						

### Social History

Do you use tobacco?     Yes     No     Former    Type of tobacco used? \_\_\_\_\_/\_\_\_\_\_  
 Packs per day? \_\_\_\_\_    Years smoked? \_\_\_\_\_    Year Quit? \_\_\_\_\_

Do you drink alcohol?     Yes     No     Former    Year Quit? \_\_\_\_\_  
 Type? \_\_\_\_\_    How much per week? \_\_\_\_\_  
 Amount? \_\_\_\_\_    Last Drink? \_\_\_\_\_

Do you use illicit drugs?     Yes     No     Former    Year Quit? \_\_\_\_\_  
 Type? \_\_\_\_\_    How much per week? \_\_\_\_\_  
 Amount? \_\_\_\_\_    Last use? \_\_\_\_\_

Patient name: \_\_\_\_\_    M.R. # \_\_\_\_\_

Please list your preferred and alternative pharmacies below:

**Preferred Pharmacy**

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

**Alternative Pharmacy**

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

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**Health Maintenance**

Please indicate if you have had the following items performed and the date to the best of your knowledge:

			Date of last
Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Stool cards for hidden blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Annual / Wellness Exam	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Colonoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Sigmoidoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Influenza Vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Pneumococcal Vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Tetanus Vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
DEXA Scan (Bone Density)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Gyn Exam	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Mammogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___
Breast Exam	<input type="checkbox"/> Yes	<input type="checkbox"/> No	___/___/___

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Additional comments or information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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I certify the above information is complete, correct and accurate to the best of my ability.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office use only:

- Provider reviewed      Initials: \_\_\_\_\_ Date: \_\_\_\_\_
- Data keyed in NextGen      Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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Patient name: \_\_\_\_\_ M.R. # \_\_\_\_\_