NEW PATIENT PAPERWORK

NAME: ____ DOB: ________________

ADDRESS: ____

HOME #___________________________ CELL #___________________________

EMPLOYER/OCCUPATION: ____

PRIMARY INSURANCE AND ID#____

SECONDARY INSURANCE AND ID#_______________________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ________________________________

WHAT IS THE REASON FOR YOU VISIT? _________________________________

____RESULT OF ACCIDENT? ______

PRIMARY CARE PHYSICIAN AND # ______________________________________

ENDOCRINOLOGIST AND # ____

PHARMACY NAME AND ADDRESS_______________________________________

CURRENT MEDICATIONS: ____

____

ALLERGIES: ____

LAST FLU SHOT DATE: _____________________

PNEUMOCOCCAL VACCINATION DATE: ______________________

HISTORY AND PHYSICAL

Medical History: ___Alcoholism ___Blood disorders ___Circulation problems
___Breathing issues ___Liver ___Sleep apnea ___Gout ___Allergies ___Heart disease ___Asthma
___Heart murmur ___Stomach/bowel ___Depression ___Anxiety disorder ___Mental illness
___Kidney disease ___Blood clot ___High cholesterol ___HIV __CVA
___High blood pressure ___Hepatitis ___Neuropathy *(specify)* __________________
___Diabetes (type 1, type 2) ___ Skin disorders ___Stroke
___Thyroid disease *(specify)* _____________ ___Arthritis *(specify)* _______________
___other (*specify)* ___________________________________
Are you pregnant? Yes No **Are you nursing?** Yes No

Surgical History: ____

Social History: Do you smoke? ___Yes ___No If yes how many packs per day? _________Do you drink alcohol? ___Yes, everyday (5-7 days/week)___Yes,occasionally/socially___No/Rarely
Substance abuse: ___Yes, I have a current substance abuse problem.
Please specify: ____
___Yes, I had a past substance abuse problem.
Please specify: ____
___No, I have never had a substance abuse problem
What is your occupation? _____________________________________
Do you exercise regularly? ___No, I do not exercise regularly
___Yes, I do the following regular exercise: __________________________________

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*
Alzheimer's ______________ Depression ______________ Arthritis _____________________
Diabetes ________________ bleeding disorders ________________ Emphysema___________
Blood clot _____________ Heart disease ________________Cancer _____________________
High Blood Pressure _____________Cataracts _____________ Neurological _____________
Circulation problems_______________ Strokes ______________Other (specify): ___________

Review of Systems:
Cardiovascular: __leg pain when walking __fever __chest pain/pressure __leg swelling __cold hands/feet __fainting __palpitations __vascular disease __valve problems __**NONE**

Genitourinary: __increased urgency __excessive urination __kidney disease __kidney stones __**NONE**

Gastrointestinal: __abdominal pain __heartburn __blood in stool __vomiting __ulcers __constipation__diarrhea __trouble swallowing __decrease appetite __increase appetite __**NONE**

Integumentary: __athletes foot __nail abnormalities __keloids __itchiness __dry, scaly skin __**NONE**

Hematologic: __lower leg ulcers __sickle cell disease __anemia __blood thinners __clotting disorders__**NONE**

Neurological: __tingling __weakness __seizures __numbness __headaches __tremors __paralysis __**NONE**

Musculoskeletal: __back pain __joint swelling __muscle weakness __muscle pain __neck pain __sciatica __joint stiffness __joint pain __joint instability __arthritis __**NONE**

Respiratory: __chest pain __wheezing __COPD __coughing __snoring __shortness of breath __emphysema __**NONE**