New Patient Information

Name: ______________________________ DOB: ____________________________

Social Security Number: _______________________ Marital Status: ______________________

Address (including city, state & zip code): ____

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Primary Phone Number: _______________ Secondary Phone Number: ____________________

Email Address: ____

Would you like to participate in our patient portal? **Yes** **No**

Primary Care Physician (name, address & phone number): __________________________________

____

Pharmacy (name, address & phone number): ____

____

Emergency Contact (name, relation & phone number): ___________________________________

____

Reason for your visit today: ____

Have you had any recent blood work or imaging (ultrasounds, CT Scans, MRI, Etc.)? **Yes** **No**

If so, what/where? ____

Do you have any allergies? ____

Have you had the flu and/or pneumonia shot this year? **Yes** **No** If so, when? ______________

Have you had a colonoscopy in the last 10 years? **Yes** **No** If so, when? __________________

Do you smoke? **Yes** **No** How much/how often? ____________________________________

Do you drink? **Yes** **No** How much/how often? _____________________________________

Do you use recreational drugs? **Yes** **No** Which ones/how often? ________________________

Do you consume caffeine? **Yes** **No** In which form/how often? __________________________

Please list any relevant family medical history (diagnosis and relation to patient):

____

____

Please list your current medical conditions/diagnoses:

____

Please list any surgeries and/or medical procedures you have had:

____

What is your height? ________________ What is your weight? ________________________________

Please list all medications you are currently taking (name and dosage):

____

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If you need to be scheduled for radiology or other testing, what facility do you prefer? _______________

Do you see any of the following specialists?

Type	**Yes** **No**	Name of Physician	Physician Phone Number/Address
Cardiologist	**Yes** **No**		
Nephrologist	**Yes** **No**		
Gynecologist	**Yes** **No**		
Endocrinologist	**Yes** **No**		
Oncologist	**Yes** **No**		
Hematologist	**Yes** **No**		
Other (type)	**Yes** **No**		