New Patient Information

Name _____ Date of Birth _____

Mailing Address _____ City/State _____ Zip Code _____

Phone Number _____ Email Address _____

☐ Male ☐ Female ☐ Not Specified

Do you have insurance or expect to have insurance by the time your appointment is scheduled? ☐ Yes ☐ No

If self pay, do you want information on our sliding fee program? ☐ Yes ☐ No

List any specialist that you see _____

Previous primary physician(s) _____

Reason for adding new primary care provider _____

List any physician preferences _____

A list of clinic providers can be found on the enclosed letter or visitcitizensmemorial.com for a comprehensive profile of each family practice healthcare provider.

Previous Surgeries

Surgery	Date

Do you wear glasses? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No

Social History

TOBACCO USE ☐ Current smoker ☐ Former smoker ☐ Smokeless tobacco

Pack(s) ___ per day ___ Per week ___ Per month

ALCOHOL USE ☐ Never ☐ Occasionally ☐ Daily

Drinks ___ Per day ___ Per week ___Per month

Comments _____

_____

SUBSTANCE ABUSE ☐ Current ☐ Former

Comments _____

_____

Primary health concern _____

_____

Who lives in your home? _____

List all allergies _____

_____

Preferred pharmacy _____

Current Medications

List all prescriptions, over the counter medications, and supplements that you are currently taking. Please use a separate sheet of paper if needed.

Example: Aspirin	81 mg	1 tablet once a day	3 years

Please provide the information that applies to you.

Date of last eye exam _____

Date of last dilated eye exam _____

Date of last colonscopy _____

Date of last bone density _____

Number of pregnancies _____

Number of miscarriages _____

Number of full term pregnancies _____

Date of last mammogram _____

Abnormal ☐ Yes ☐ No

Date of last pap smear _____

Abnormal ☐ Yes ☐ No

Date of last menstrual period _____

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CURRENT AND PAST MEDICAL HISTORY

Name _____

Place a check in the box if applicable. C= Current P= Past F= Family history

C	P	F	
			Blood/Cancer:
			Blood transfusions
			Blood transfusions reactions
			Blood disorders
			Anemia
			Cancer
			Chemotherapy
C	P	F	
			Cardiovascular:
			High blood pressure
			Atrial fibrillation
			Stroke
			Heart attack
			Heart murmur
			Pulmonary embolism
			Congestive heart failure
			Blood clots
C	P	F	
			Respiratory:
			Pneumonia
			COPD
			Asthma
C	P	F	
			Gastrointestinal:
			Heartburn/Reflux
			Ulcer
			Liver disease
C	P	F	
			Endocrine (Glands):
			Diabetes
			Diabetes ketoacidosis
			Thyroid disease

C	P	F	
			Musculoskeletal:
			Degenerative disc
			Back pain
			Arthritis
			Fractures
			Osteoporosis
C	P	F	
			Urinary:
			Kidney disease
			Urinary tract infection
			Kidney stones
			Prostate problems
C	P	F	
			Women's Health:
			Menstrual problems
			Endometriosis
			Fibroids
			Pelvic inflammatory disease
			Pregnant
			Preterm pregnancy/birth
			Pregnancy complications
			Lactating
C	P	F	
			Infections/Viruses:
			MRSA
			Vancomycin resistance
			Hepatitis
			HIV
			Recurrent ear infections
			Sexually transmitted disease

C	P	F	
			Neurological (Brain):
			Headaches/Migraines
			Dementia
			Seizures
C	P	F	
			Behavioral Health:
			Depression
			Anxiety
			Bipolar disorder
			Suicide attempt
			Schizophrenia
			ADHD/ADD
			Behavioral problems
			Psychiatric treatment (inpatient)
C	P	F	
			Substance Use:
			Drug Use
			Tobacco Use
			Alcohol Use
C	P	F	
			Miscellaneous:
			Glaucoma
			Genetic disorder
			Birth defect
			Prior intubation

Other _____

_____