ADULT NEW PATIENT PAPERWORK

Name:_____ Date:_____

Nickname: _____ Age: _____

Why are you seeing the doctor today? _____

Please list any prescription medicines you take (with dosage) and any over-the-counter pills or herbs:

_____

_____

_____

_____

Do you have allergies to medicines or latex? Yes / No Please List: _____

_____

Health Maintenance Questions:

Please list **approximate dates** next to any of these that you have had:

Tetanus Shot		Colonoscopy	
Cholesterol Checked		Bone Density Test	
PPD (tuberculosis test)		Pneumonia Vaccine	
Pap Smear		Shingles Vaccine	
Mammogram		Screening for Hepatitis C	

Surgeries or Hospital Stays:

Please list approximate dates next to any of these you have had:

Tonsillectomy		Eye Surgery	
Appendectomy		Dental Surgery	
Gallbladder Removal		Open Heart Surgery	
Joint Replacement		Cesarean Section	
Back Surgery		Hysterectomy	
Tubes in Ears		Tubal Ligation/Vasectomy	
Please list other surgeries:			

Family History

	Medical Problems	If deceased, Age and Cause of death
Father		
Mother		
Brothers (#)		
Sisters (#)		
Children (#)		

Are there any other medical conditions in your family that I should know about?

_____

Social History

Occupation? _____

Who lives with you? _____

Do you use tobacco? _____ Have you ever used tobacco? _____ How Much? _____

Do you vape? _____ How Much? _____

Do you drink alcohol? _____ How Much?_____

Do you use marijuana?_____ Any other recreational drugs? _____

Have you ever used illegal IV drugs? _____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE

General

- _____ Any appetite or weight changes
- _____ Fatigue
- _____ Fevers or night sweats

Eyes

- _____ Vision Changes
- _____ Blurred Vision or Double Vision
- _____ Glaucoma/Macular Degeneration

Ear/Nose/Mouth/Throat

- _____ Trouble hearing or ringing in ears
- _____ Frequent Ear Infections
- _____ Hay Fever or Allergies
- _____ Bloody Noses
- _____ Trouble Swallowing

Heart

- _____ Heart Racing or Skipping Beats
- _____ Chest Pain
- _____ Fainting
- _____ High Blood Pressure or High Cholesterol
- _____ Heart Attack

Respiratory

- _____ Asthma or Emphysema
- _____ Shortness of Breath or Cough
- _____ Wheezing
- _____ Tuberculosis
- _____ Sleep Apnea

Gastrointestinal

- _____ Diarrhea or Constipation
- _____ Frequent Heartburn
- _____ Blood in Stools or Black Colored Stools
- _____ Liver Disease or Hepatitis

GU

- _____ Kidney Stones
- _____ Trouble Urination
- _____ Frequent Bladder Infections
- _____ Ever Had a Sexually Transmitted Disease
- _____ Problems with Sex

Musculoskeletal

_____ Arthritis or Joint Pain
_____ Muscle Aches or Fibromyalgia
_____ Back Problems or Herniated Discs

Skin

_____ Psoriasis or Eczema
_____ Skin Cancer
_____ Rashes
_____ Fingernail or Toenail Changes

Neurologic

_____ Memory Problems
_____ Seizures
_____ Numbness, Tingling, or Weakness
_____ Dizziness
_____ Headaches (Migraines)

Psychiatric

_____ Depression or Anxiety
_____ Mental Illness
_____ Sleep Problems

Endocrine

_____ Thyroid Disease
_____ Diabetes or Blood Sugar Problems

Heme/Lymph

_____ Excessive Bleeding or Bruising
_____ Blood Transfusion
_____ Enlarged Lymph Nodes

Infectious Disease

_____ History of Chickenpox
_____ Chickenpox Vaccine
_____ History of Mumps
_____ History of Rheumatic Fever
_____ History of Hepatitis
_____ Been tested for HIV

For Women Only

_____ Date of Last Menses
_____ Problems with Periods
_____ Hot Flashes or Menopause Problems
_____ Vaginal Discharge
_____ Pain with Sex or Bleeding after Sex

PATIENT REGISTRATION

(Fill out all information. Please Print.)

Patient's Name: _____ Sex: Male / Female

Guardian (if under 18): _____

Marital Status: Single / Married / Divorced / Widowed

Race: Caucasian/ African American/ American Indian/ Asian/ Other

Ethnicity: Non-Hispanic/ Hispanic Language: English/Spanish/Other: _____

Birth Date: _____/_____/_____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Pharmacy: _____ Mail Order Pharmacy: _____

Guarantor (party responsible for portion of bill not payed by insurance)
Name: _____
Address: _____
Home Phone: _____

ADDITIONAL INFORMATION

Spouse: _____
Cell Phone: _____
Work Phone: _____

Emergency Contact: _____
Relationship to Patient: _____
Home Phone: _____
Cell Phone: _____

INSURANCE INFORMATION

PRIMARY

SELF Pay (check here if self pay): ☐

Primary Insurance: _____
Subscriber Name: _____
Subscriber's Date of Birth: _____ Relationship to patient: _____

SECONDARY

Secondary Insurance: _____
Subscriber Name: _____
Subscriber's Date of Birth: _____ Relationship to patient: _____

I understand that I am financially responsible for any balance not covered by my insurance.

Printed Name: _____ Relationship to patient: _____

Signature: _____ Date: _____