Kell Medical PA

_____
Chart # Appointment Date/Time:

New Patient Packet

Patient's legal name: _____ _____
Last First M.I. (Maiden)

Preferred or other known-by name: _____

Home address: _____
Street City State Zip

Social Security number: _____/____/_____ **Date of birth:** ___/____/_____ **Sex:** F ☐ M ☐

Home phone: (____) _____ **Cell phone:** (____) _____ **Work phone:** (____) _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ More than one race
☐ Native Hawaiian ☐ Pacific Islander ☐ Unreported/Refused to report

Ethnicity: ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Hispanic/Latino ☐ Unreported/Refuse to report

Email: _____

Emergency contact: _____
Last First Relationship Phone Number

What are the most important medical problems you have now that you want to be seen for? (Please answer)

_____

_____

*** Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.*

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INSURANCE INFORMATION

***Primary Medical Insurance** **Secondary Medical Insurance**

Insurance Carrier: _____ _____

Policy #: _____ _____

Group #: _____ _____

Subscriber: _____ _____
(self/spouse/parent name)

Subscriber's Soc. Sec. #: _____ _____
(If not the patient)

Subscriber's DOB: _____ _____
(If not the patient)

Relationship to Patient: _____ _____

If you are currently uninsured please complete the following:

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge.

_____ _____ _____
Name of Patient (Print) Signature of Patient Signature Date

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Medication

List any prescription, herbal or over-the-counter medications that you are currently taking.

Medication name*	Strength	Dosage/Directions
Example: Aspirin	325mg	1 tab daily

** If you need more room to list your medications, please write down your other medications on a separate piece of paper and bring it with you to your appointment.*

Please list your preferred pharmacy name and phone number: _____

Do you have allergies to medications? ☐ Yes ☐ No

If yes, please list drug(s) and reaction(s): _____

_____

_____

Health Maintenance

Date of last physical/preventative medical exam: _____

Adults only: Date of last cholesterol test? ___/___/____

Women ages 21+ last pap smear: ___/___/____

Adults ages 50+

Date of last colonoscopy: ___/___/____

Women ages 40+ last mammogram: ___/___/____

Adults ages 65+

Last osteoporosis screening (Dexa Scan): ___/___/____

Men ages 40+ last prostate exam: ___/___/____

Obstetric and Gynecological History: (Women Only)

Age of first menstrual period: ____

What was the first day of your last period: ___/___/____

Number of pregnancies: ____ Living: ____

Check if these apply to <u>you</u>: ☐ Bleeding between periods ☐ Heavy periods ☐ Extreme menstrual pain ☐ Hot flashes

☐ Vaginal itching,burning, or discharge ☐ Waking in the night to go to the bathroom ☐ Breast lump or nipple discharge ☐ Painful intercourse

MEDICAL PATIENT/HEALTH HISTORY

Medical History

Please check all that apply.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots
- ☐ Cancer
- ☐ Chest pain
- ☐ Circulation problems
- ☐ Crohn's disease
- ☐ CVA (stroke)
- ☐ Depression
- ☐ Diabetes
- ☐ Enlarged prostate
- ☐ Gallbladder disease
- ☐ Heart failure
- ☐ Heartburn
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease/ Emphysema
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Seizure disorder
- ☐ Ulcers
- ☐ Valve disease

Surgical History

Please list all prior surgeries. Include dates and any complications.

1. _____
2. _____
3. _____
4. _____
5. _____

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Sexual History

Do you have any concerns about possible exposure to sexually transmitted diseases that you would like to discuss or be tested for? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No

Have you ever been treated for a sexually transmitted disease? ☐ Yes ☐ No

Birth Control Method: ☐ Condoms ☐ IUD ☐ Nexplanon ☐ None ☐ Pill ☐ Other _____

Tobacco Use History

Uses tobacco: ☐ Currently ☐ Formerly ☐ Never

Tobacco type: ☐ Cigarettes ☐ Chewing ☐ Cigar ☐ Vape ☐ Other _____

Amount per day: _____ (packs, ounces, cigars, vape) Number of years: _____

Tobacco cessation ever discussed: ☐ Yes ☐ No

Secondary smoke exposure: ☐ Yes ☐ No

Alcohol Use History

Drinks alcohol: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Type: ☐ Wine ☐ Beer ☐ Liquor Describe type: _____

Caffeine Use History

Drinks caffeine: ☐ Coffee ☐ Soda ☐ Tea ☐ Energy drinks

How many daily: _____

Recreational, Narcotic or Illicit Drug Use History

Uses recreational, narcotic or illicit drugs: ☐ Currently ☐ Formerly ☐ Never

If currently or formerly, please indicate drugs used: _____

Have you ever sought treatment for drug use: ☐ Yes ☐ No

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Family History

Please indicate if your mother, father or sibling has any of the following diseases now or if it was their cause of death (COD). Please also indicate if aunt/uncle/grandparents in the “other” box. Check all that apply. If you are not sure, please place a question mark (?) in those boxes.

	MOTHER		FATHER		SISTER(S)		BROTHER(S)			OTHER	
	Yes	COD	Yes	COD	Yes	COD	Yes	COD	Yes	COD	Relationship
Diabetes											
Heart disease											
High blood pressure											
High cholesterol											
CVA (stroke)											
Kidney disease											
Alcoholism											
Alzheimer's disease											
Asthma											
Blood clots											
Cancer											
Circulation problems											
Depression/anxiety											
Development delays											
Eczema											
Irritable bowel disease											
Mental illness											
Migraines											
Obesity											
Seizure disorder											
Substance abuse											
Other family history											