NEW PATIENT INFORMATION FORM (Call In)

Today's Date ____ /____ /____

Reason for referral: (examples: New PCP? Psych? Both? Unhappy with old care?)

Where have you been receiving medical care?:

Hospitalizations in the last 2 years? If yes, where? Dates?

Allergies:

Medications:

_____

_____

_____

PMHx: (circle yes or no)

Anemia	yes	no
Ar thritis	yes	no
Asthma/Bronchitis/Emphysema	yes	no
Bleeding/Bruising	yes	no
Blood Disorder	yes	no
Cancer….(type):	yes	no
Depression/Emotional Problems	yes	no
Diabetes	yes	no
Drug/Alcohol Dependency	yes	no
Epilepsy/Seizures	yes	no
Hay Fever/Sinus Problems	yes	no
Heart Problems	yes	no

Hepatitis	yes	no
High Blood Pressure	yes	no
Immune Disorders	yes	no
Intestinal Problems	yes	no
Kidney Disease	yes	no
Liver Disease	yes	no
Lung Disease	yes	no
Skin Disease	yes	no
Stroke….(when):	yes	no
Stomach Ulcers	yes	no
Thyroid Disease	yes	no

Do you smoke? Yes or no
Do you drink alcohol? Yes or no

Do you suffer from any pain? Scale of 1-10. _____

Do you have a DPOA? Yes or no (If yes, please make sure we collect) Are you a full code or DNR? (circle one)