Peter Krause, MD
Family Medicine

New Patient Information

Date:	**Social Security #**
Patient Name	**Marital Status: (circle one)** Single Married Partnered Divorced Widowed Separated
Address:	**Gender** Male Female other
Home phone	**Ok to leave message on: (circle all)**
Mobile	home work mobile
Work phone	
Emergency Contact (name, relationship and phone number):	
Email Address:	
Laboratory (blood work): **(Physicans Choice HMO must use Wespac Labs)**	
Language spoken:	**Pharmacy:**

***Please provide your insurance card and drivers license to the front office**
***Would you like to give a family member (includes spouses) permission to discuss your healthcare? If yes, please ask for form from front office staff**

Ok to submit vaccine information to CAIR's database? Y N
OK to share medical information with other medical providers when requested? Y N
We pull in medication history & check CURES if available - this is our policy to do so automatically.

Surgical History (please list procedure and date)	**Medication allergies** Y N **Please List:**
Medications (name, dose and frequency)	
What specialist (if any) do you see and what do you see them for? (Use extra sheet if necessary)	

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Past medical history

ADHD	Headaches
AIDS/HIV	Heart Disease
Abuse/Domestic Violence	Heart Problem/Murmur
Allergies	Hepatitis A,B,C
Anemia	High cholesterol
Anxiety	Hospital admission
Arthritis	Hypertension
Asthma	Hyperthyroidism
Autism	Hypothyroidism
Bedwetting	Infertility
Birth Defects	Kidney Disease
Bladder/Kidney problems	Kidney Stones
Blood disorder	Liver Disease
Blood transfuion	Lung Disease
Breast Cancer	Menierer's Disease
Breast Problem	Mental Illness
COPD	Muscle/Joint or Bone disorder
Cancer	Nasal polys
Chicken Pox	Obesity
Chronic Ear Infection	Osteoporosis
CHF	Other
Depression	Colon polys
Diabetes	Reflux/GERD
Difficulty Swallowing	Seizures
Diverticulitis	Skin problems
Ear/Hearing problems	Stroke
Eating disorder	TB
Eczema	Pulmonary Embolism
Endometriosis	TB
Fibromyalgia	Varicosities
GI issues	Vision/Eye problems
Gout	MRSA exposure
Head Injury/Concussion	

Social history

Smoking status		Current	Former	Never
Ecig/vaping use		Current	Former	Never
# of years smoking				
How much?		PPW-#	PPD - #	
Able to care for self?		Y	N	
Household		Alone	with others	
Advanced directive?		Y	N	
Exployed?		Y	N	
Highest level Education?				
# of children				
Caffeine use		Y	N	
Recreational drugs		Y	N	
Specific diet?				
Exercise level		None	Moderate	Heavy
Hard of hearing?		Y	N	
Legally blind?		Y	N	
Sexually active?		Y	N	
Sexual orientation		Hetero	Homo	Bi
Smoke alarm?		Y	N	
Chew tobacco?		Y	N	
Seat belt?		Y	N	
Sunscreen use?		Y	N	
Alcohol use?	None	Occassional	Moderate	Heavy
Stress?		Low	Moderate	High

Vaccines	Year	Screening	Year
Tdap		Colonoscopy	
Flu		Mammogram	
Pneumovax		Lung Cancer	
Prevnar		Pap/Pelvic	
Shingles		Other	
childrens vaccines (record)			

Family history (parents, grandparents, siblings)

Indicate specific family member & type of disease

Heart Disease	Diabetes
Cancer	Alcohol or substance abuse
Thyroid Disease	Lung disorder
Stroke	Other
Mood disorder	