New Patient TODAY'S DATE:_____

Patient name	Date of birth	Age	Gender

Date of Last Wellness	(Medicare B eligibility date)	Race	Primary Language Spoken

BP	HR	RR	HT	BMI	WEIGHT	TEMP

SOCIAL HISTORY

TOBACCO?	Never	Current smoker	*No. years smoked?*	*Packs per day*	Year Quit	Other tobacco
ALCOHOL?	Never	Few times/year	1-2 per day	3 or more per day	Past history of abuse…Year quit:	
CAFFIENE?	Never	Occasional	Daily	**DIET:**		

DESCRIBE ANY HISTORY OF DRUG USE OR ABUSE	EXERCISE ROUTINE

Marital Status (Circle one)	Number of pregnancies:	Number of children
S M W D	_____ Sexual partner preference: M F	_____ Living _____ Deceased

Highest level of education completed	Current occupation	If retired, what type of work did you do?

HOME ENVIRONMENT	Private home	Assisted Living	Nursing Home	Other

FUNCTIONAL / SAFETY SCREEN (*65 AND OVER*)

Do you need someone else to drive for you?	Yes	No	Do you have any difficulty feeding yourself?	Yes	No
Do have difficulty with mobility? (getting out of bed, walking, or getting in/out of a chair)	Yes	No	Do you have difficulty getting dressed?	Yes	No
Do you have difficulty with grooming? (combing hair, shaving, brushing teeth)	Yes	No	Do you need help with your shopping?	Yes	No
Do you need help with housekeeping?	Yes	No	Do you need help managing your money?	Yes	No
Do you need help managing your medications?	Yes	No	Do you need help using the telephone?	Yes	No
Do you have stairs in your home without handrails or with poor lighting?	Yes	No	Do you have difficulty with balance?	Yes	No
Have you noticed any hearing difficulties?	Yes	No	Does your bladder sometimes leak?	Yes	No
Do you have a living will or advanced directive?	Yes	No	Have you had days where you felt very little pleasure in Activities **during the past 2 weeks** I Yes I No Have you felt down, depressed or hopeless I Yes I No		

Do you have regular or frequent pain?	None	Mild	Moderate or occasional	Continuous	Severe

Have you fallen DURING THE LAST 12 MONTHS?	No	Only once, no injury	Two or more times	Injury that required medical attention

FAMILY HISTORY (Mark "X" if positive and list approx. age if known.)					
	Mother	**Father**	**Sister**	**Brother**	**Child**
Breast Cancer					
Ovarian Cancer					
Colon Cancer					
Prostate Cancer					
Heart Attack, stent, or bypass surgery					
Stroke					
High cholesterol					
High blood pressure					
Diabetes					
Dementia					
Aneurysm					
Sudden death or died in sleep <55 yrs old					

MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR ANY OF THE FOLLOWING?

	High blood pressure		Reflux or esophageal strictures		Migraines
	High cholesterol		Ulcers		Seizures
	Heart attack / angina / stent/ bypass		Irritable Bowel / Spastic Colon		Brain or spinal cord abnormalities
	Heart failure		Crohn's Disease		Nerve condition of hands or feet
	Heart valve abnormality		Ulcerative Colitis		Skin disease
	Abnormal heart rhythm		Colon polyps		Peripheral artery disease (PAD)
	Diabetes		Diverticulosis / diverticulitis		Anxiety
	Thyroid problems		Liver problems		Depression
	Bleeding or anemia		Kidney or bladder problems		Drug or alcohol abuse or addiction
	Blood clots		Prostate problems		Dementia
	Blood transfusion		Autoimmune Disease		ADD
	Cancer		Fibromyalgia		Multiple Sclerosis
	COPD / Emphysema		Osteopenia / osteoporosis		Other Neurological or Psychiatric Condition
	Asthma		Stroke or TIA		Immune Deficiency
	Sleep apnea				

OTHER:

Hospital visits / Reason	**Facility**	**Attending Physician**	**Dates**	**Previous Surgeries / Year**

NAME _____ **DATE** _____

PROVIDER LIST (Please list all used /seen during past year)			
Physicians	**Reason**	**Other Physician / Therapist / Chiropractor**	**Reason**

Medical Supplier / DME company	**For**
Local Pharmacy	**Mail Order Pharmacy**

MEDICATION LIST (*List all prescription, non-prescription, supplements, herbals, other.)*		
Name of Medication *Example: Ibuprofen*	**Strength or Dose** *200mg*	**Frequency and route** *2 tablets by mouth 3 times a day*

ALLERGY LIST			
ALLERGY	**REACTION**	**ALLERGY**	**REACTION**

VACCINATIONS					
	YEAR		*YEAR*		*YEAR*
Influenza (Flu Shot)		Pneumovax 23 (Pneumonia)		Tetanus / pertussis (TDaP)	
Shingles		Prevnar 13 (Pneumonia)		Tetanus / NO pertussis (dT)	
Hepatitis A		Hepatitis B		Gardasil	

SCREENING TESTS				
TEST	*NONE*	*DATE IF DONE*	*DR. OR FACILITY*	*(FOR OFFICE USE) RECOMMENDED*
Colonoscopy				
Stool test for blood				
Pap smear / pelvic exam				
Mammogram				
Bone Density				
Prostate cancer screen				
Electrocardiogram (EKG)				
Eye exam / Glaucoma screen				
Hearing evaluation				
Hepatitis C Screening				
Abdominal Aortic Screening (abdominal ultrasound)				

For office use:

COUNSELING:

X		Education	Recommended	Scheduled
	Diet / Nutrition			
	Advance Directive			
	Smoking Cessation			
	Alcohol Use			
	Home Safety			
	Exercise			
	Vaccines			
	Diabetic Education (DSMT)			
	Safe Sex Practices			
	Aspirin therapy			
	Calcium and / or vitamin D therapy			
	Cognitive evaluation			
	Driving assessment			
	Social Services			

***** FOR YOUR SAFETY, IT IS OUR OFFICE POLICY THAT REFILLS MUST BE REQUESTED BY THE PATIENT. *****
WE DO NOT FILL PRESCRIPTIONS REQUEST FROM A PHARMACY.