Wellness Family Medicine: New Patient Intake Form

Legal Name: ___________________________________ DOB: ____________________ Date: _________

MEDICAL HISTORY Please check all that apply: *Pulmonary* o Emphysema o Pneumonia o Bronchitis o Asthma

Cardiovascular o Stroke o High Blood Pressure o Elevated Cholesterol o heart attack o stroke

Endocrine: Diabetes If yes, how long _______and how much did you weigh at diagnosis____________

GI: o Hepatitis A or B o Hepatitis C o Cirrhosis o Gallbladder Disease o Ulcers o surgery _____________

GU: o Frequent urination/Bladder Infections o Sexually Transmitted Infections o Prostate Trouble

Orhtopedic: o Arthritis o Osteoporosis o Fractures o Low back pain o Surgeries ____________________

Neuro/Psych o Migraines o Depression o Anxiety or Panic Disorder o Post-traumatic Stress Disorder o Alcohol or Substance Use Problem o Other: _____________________________

SYSTEMS REVIEW *General*: o Recent: weight loss o weight gain o Fatigue o Fever o Night sweats

Skin: o Rashes o Lumps o Itching o Dryness o Color changes o Hair and Nail changes o skin cancer

Head: o Headaches o Head Injuries o Dizziness

Eyes: Date of Last Eye Exam: ______________ o Eye pain o Double vision o Glaucoma o Cataracts o

ENT: o Frequent Colds o Nasal stuffiness o Hay fever o Nosebleeds o Sinus trouble o Allergies: dust/animal/seasonal Ears: o Hearing loss o Ear pain o Ringing in the ear Mouth and Throat:

Heart: o chest pain o rhythm problems o abnormal heart valve o High blood pressure o poor circulation

Respiratory: o chronic cough o shortness of breath o wheezing

GI: o change in bowel movements o blood per rectum o nausea o vomiting

Urinary: o frequent bladder infections o nighttime urination o incontinence

Ortho: o arthritis o joint pain requiring medicine o calf pain with walking

Neuro: o TIA or stroke in past o memory loss o recent numbness or weakness o history of seizure

Heme/Lymph: o bleeding tendencies/bruising o history of anemia o fluid accumulation in arms/legs

Breasts: o pain o discharge o other changes or abnormalities.

Smoking: o yes. O no If yes, how many packs per day ____________. How many years ___________

Alcohol: o yes o no. If yes, how many drinks/wk _________ preferred type of alcohol ____________

Family History: What medical problems do/did your mother and father have?

Medications: Please list Rx and over the counter meds on back of this form. Include writing MD/NP

Wellness Family Medicine

Patient Information

Name: ______________________________ SS#: ______________

(First) (MI) (Last)

Mailing Address ______________________________________

(Street or PO Box) (City) (State) (ZIP)

Date of Birth: ______________ Age: ___ Marital Status: _________

Race: ____ Ethnicity: _____ Sex:__ Language: ______________

English/Spanish/French/Other

Home Telephone: ______________ Business:( )________________

Cellphone: __________________ Email: ______________________

Employer:_____________________ Address:_________________

Spouse/Parent's Name: _________________________________

Spouse/Parent's Employer: ______________________________

Are you, the patient, covered by spouse or parent's insurance? _______

Spouse/Parent's DOB: ______________ Spouse/Parent's SS#________

EMERGENCY CONTACT PERSON:

____

(Name) (Phone) (Relationship)

LONG TERM INSURANCE AUTHORIZATION:

I request payment of authorized benefits be made on my behalf to Wellness Family Medicine for any healthcare services rendered to me by this facility.

I authorize any holder of medical information about me to release to health care financing administration and/or my other insurance companies any information to determine benefits payable. I understand that I am responsible for any amounts approved but not covered by my insurance.

SIGNATURE:_____________________________DATE:____________

WELLNESS FAMILY MEDICINE

Request for authorization for disclosure of Protected Health Information to family member(s), friend(s) or caregiver(s)

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

Patient Signature:____________________________________

Patient DOB:______________________

Mother's Maiden Name:________________________________

If the person(s) authorized above call for access to your HPI, they will have to give the above identifiers in order to have access to the information over the phone. This includes billing information. Picture ID will be requested if requesting access in person.

WELLNESS FAMILY MEDICINE/UPSTATE OCC MED

Date : ______________________________

Name: ______________________________

Please list below any medications, including over-the counter, that you have taken in the past 30 days. If prescription, please list the physician who prescribed it to you and for what reason you are taking the medication.

Medication	Reason for taking	Physician

Have you been to see a physician in the past 30 days, urgent care or emergency room? If so, where and for what reason did you go?

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Signature: ____ *Date:*_____________________