



New Patient Information

First Name: _____ MI. _____ Last Name + Suffix: _____

Prev Last Name: _____ Date of Birth: _____ Sex: M or F

Race: _____ Language: _____ Ethnicity: _____ SSN: _____

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Contact Preference: Home Mobile Work Marital Status: _____

Referring Physician: _____ PCP: _____

If Patient is a minor:

Mother's First Name: _____ Mother's Last Name: _____

Father's First Name: _____ Father's Last Name: _____

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Address: _____

Medication History Authority Yes No
(Gives us authorization to get your medication history from your pharmacy)

Insurance Information

Name of Subscriber to Insurance: _____ Relationship: _____

Subscriber's DOB: _____

If **TRICARE**: Standard Prime For Life Sponsor's SSN: _____



Reason for Visit _____

Medications

List Current Medications (please include dosage):

List Drug Allergies (please include reaction):

Medical Conditions

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Developmental | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sleep Disorders |
| Disorder | Delay | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Speech Delay |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Autoimmune Disorder | |

Past Surgeries (please include year of surgery):

- | | |
|--|---|
| <input type="checkbox"/> Ear Surgery _____ | <input type="checkbox"/> Neck Surgery (ie thyroid) _____ |
| <input type="checkbox"/> Facial Surgery _____ | <input type="checkbox"/> Tonsillectomy/ Adenoidectomy _____ |
| <input type="checkbox"/> Nasal / Sinus Surgery _____ | <input type="checkbox"/> Vocal Cord Surgery _____ |
| <input type="checkbox"/> Other _____ | |



Social & Family History

Do you smoke? Y N If yes, how often? _____ How long? _____

Do you drink alcohol? Y N If yes, how often? _____

What is your Occupation? _____

Has anyone in your immediate family had?

<u>PROBLEM</u>	<u>RELATIONSHIP</u>	<u>ONSET AGE</u>	<u>AGE OF DEATH</u>	<u>NOTES</u>
Bleeding Problems				
Cancer				
Diabetes				
Heart Problems				
Kidney Disease				
Strokes				
Thyroid				
Tuberculosis				
Other				

Reviewing Physician's Initials: _____ Date: _____