CAMC IM RESIDENT CLINIC NEW PATIENT HEALTH INFORMATION

Your answers on this form will help your health care provider better understand your medical concerns and conditions. **Bring this completed form with you to your establish care visit for primary care along with all current medication prescription bottles. If you fail to bring this completed form and medications, you will be asked to reschedule appointment.**

Patient Name: _____ **DOB:** _____

Any other needs to be addressed at appointment other than establishing care with a primary care provider:
_____
_____

FORMER Primary Care Physician/ "family doctor": _____
Please complete records request form included in packet and bring with you to appointment.

PREFERRED PHARMACY: _____

ACTIVE MEDICATIONS & DOSAGES:
_____
_____
_____
_____
_____

Are you presently being treated with a controlled substance for conditions such as anxiety, insomnia, or chronic pain? □ **Yes**   □ **No**
If yes, who presently prescribes this for you? _____
Please note: We will not prescribe controlled substances at your initial visit nor do we commit to continue or refill a previous prescribing provider's medication regimen. You may be asked to undergo diagnostic studies and/or request records to confirm diagnosis, in addition to starting other treatment modalities (i.e. physical therapy), or being referred to a specialist.

ALLERGY (medication, food, bee stings, etc.) **& REACTION** (how each affects you)
_____
_____

Have you seen any specialists? Please write provider name in box below.

Cardiologist	Nephrologist	Ophthalmologist	Orthopedist	ENT	Endocrinologist	Psychiatrist
Pulmonologist	Neurologist	Oncologist	Rheumatologist	Pain Specialist	Urologist	Gastroenterologist

VACCINATION HISTORY

	Pneumonia Prevnar 13 Pneumovax 23	TDAP Tetanus Diphtheria Pertussis	COVID19	Hepatitis A	Hepatitis B	Chicken Pox	Measles, Mumps, Rubella	HPV Gardasil	Shingles Zostavax Shingrix
Year Received									

PAST MEDICAL HISTORY – please check any that apply

□ Anxiety Disorder
□ Depression
□ Other psychiatric illness:

□ Seizure disorder
□ Stroke
□ Dementia
□ Thyroid disease
□ Diabetes
□ Acid reflux/stomach ulcers
□ Asthma/COPD/oxygen use
□ Sleep apnea/CPAP use
□ Tuberculosis
□ HIV/AIDS

□ Bleeding history
□ Blood Clots
□ Cancer
□ Coronary artery disease (stents/open heart bypass)
□ Gout
□ High blood pressure
□ Has pacemaker
□ Heart attack
□ Heart murmur/valve replacement
□ High cholesterol
□ Liver disease

□ Crohns/ulcerative colitis/diverticulitis
□ Kidney disease
□ Kidney stones
□ Dialysis
□ Fibromyalgia
□ Rheumatologic disease/arthritis
□ Osteoporosis/fractures
□ Leg/foot ulcers
□ Substance use disorder (tobacco/alcohol/drugs):
□ Other:

PROCEDURES /SURGERIES

Procedure	Year Performed (or age)	Physician and location	Any Results/Findings
Colonoscopy			□Normal □Abnormal/Polyps Return instructions (1/5/10 yrs):_____
Pap Smear			□Normal □Abnormal
Mammogram			□Normal □Abnormal
Other:			
Other:			

FAMILY HISTORY – please check any that apply for your parents/siblings/children

□ **Adopted/Unknown**
□ Alzheimer's disease
□ Bleeding disorder
□ Mental illness
□ Seizure disorder
□ Stroke
□ Diabetes
□ High cholesterol
□ Rheumatologic disease (i.e. lupus, rheumatoid arthritis)
□ High blood pressure
□ Heart disease

□ Kidney disease
□ Osteoporosis
□ Hip fracture
□ Cancer, please list what type(s) and relationship:
_____
_____
_____
□ Other:
_____
_____

OBSTRETRIC/GYNECOLOGICAL HISTORY

pregnancies: _____   # miscarriages/abortions: _____   date of last menstrual period or menopause: _____

I attest the above information was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____
Date: _____