Westfield Family Physicians New Patient Intake Form

Patient Name: _____Date of Birth_____

Reason for visit:_____Date of Visit_____

Past Medical History: Please review the list below and check any problems you have now or have had in the past.

O High blood pressure	O Asthma	Please list any other medical problems
O Heart disease	O Lung problems	
O Diabetes	O Kidney problems	
O Stroke	O High cholesterol	
O Cancer	O Hepatitis (A,B,or C)	
O Thyroid	O Alcohol or drug problems	
O Mental Health problems		

Women only: Number of pregnancies_____Live births_____Miscarriages_____Abortions_____

Please note any **surgeries or hospitalizations** you have had:

Type of surgery	Year
Appendix removal	
Arthroscopy	
Back or neck surgery	
Cataract surgery	
C-Section	
Gallbladder removal	
Heart surgery	
Hernia	

Type of surgery	Year
Hysterectomy	
Knee or hip replacement	
Lumpectomy	
Mastectomy	
tonsillectomy/adenoidectomy	
Tubal ligation or Vasectomy	
Colonoscopy	
Colonoscopy with polyp removal	

Hospitalization reason	year

Please list any additional surgeries:

_____

Please list any specialists you see: _____

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Health Maintenance:

Please note any preventive services you have had done and record the last date:

Service	Year
Flu shot	
Tetanus shot	
Tetanus/Pertussis shot	
Pneumonia shot	
Dental Visit	

Service	Year
Shingles Vaccine	
Mammogram(females)	
Pap Smear(females)	
PSA test (males)	
Eye visit	

Do you have a Health Care Proxy? **Yes** **No** (if no, please ask us for more information. If yes, please bring a copy to your visit)

Family History:

Have any of your close blood relatives had any of the following?

Condition	Family Member/details
Diabetes	
Heart disease/attack	
Cancer	
Mental Illness	
Alcohol or drug problems	
other	

Social History: (circle responses)

Marital status: **Single** **Married** **Separated** **Divorced** **Widowed**

Living situation: **Live alone** **Live with spouse or partner** **Live in assisted living**

List any others living in your household: _____

Highest level of education: **Less than 6th grade** **Jr. High** **High School** **College**

Occupation: _____

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Do you currently smoke? **Yes** **No** If so, how much? _____ How many years? _____

Have you *ever* smoked? **Yes** **No** How much? _____ How many years? _____

Any other tobacco use? **Yes** **No** Type: _____

Do you drink alcohol? **Yes** **No** Type and amount: _____

Do you drink caffeine? **Yes** **No** Type and amount: _____

Have you ever used street drugs? **Yes** **No** Are you still using? **Yes** **No**

If yes, which ones? Marijuana Heroin Cocaine Amphetamines Downers inhalants

Do you exercise? **Yes** **No** type and how often: _____

How many servings of fruit or vegetables do you get each day? **0** **1** **2** **3** **4** **5**

Do you eat out at restaurants weekly? **Yes** **No** How many times per week? _____

Is there any concern for your safety? (Emotional, physical or sexual abuse)? **Yes** **No**

Are you hard of hearing? **Yes** **No** What is your preferred language? _____

Do you have any problems caring for your health? (circle) **Cost** **Transportation** **Understanding**

Family problems **Insurance** **other** _____

Medications:

Please list all medications you take including doses, times per day and over the counter medications. You may attach an additional list if needed. (we also request that you bring your bottles to your visit.)

Medication/dose	times per day
ex: Enalapril 20 mg	2

Medication/dose	times per day

Please list any drug allergies: _____

Which pharmacy do you use? (name and address) _____

Patient Name: _____ Date of visit:_____

Date of Birth: _____

Please check any symptoms or problems you are having:

General: ☐ fever ☐ night sweats ☐unexplained weight loss or gain ☐ fatigue ☐ none

Skin: ☐ rashes ☐ itching ☐ changes in hair, skin or nails ☐ none

EENT: ☐ ear pain ☐ change in hearing ☐ eye problems ☐ persistent runny nose
☐ sore throat ☐ change in voice ☐ sinus trouble ☐ none

Heart: ☐ chest pain ☐ swelling in ankles ☐ palpitations ☐ none

Lungs: ☐ cough ☐ short of breath ☐ wheezing ☐ none

GI: ☐ nausea ☐ blood in stool ☐ change in bowel movements
☐ ulcers ☐ heartburn ☐ abdominal pain ☐ none

GU: ☐ blood in urine ☐ pain with urination ☐ loss of urine control ☐ none

*Women: ☐ vaginal discharge ☐ change in menstrual cycle or sexual function ☐ none

*Men: ☐ testicular pain penile discharge ☐ decreased urinary stream
☐ change in sexual function ☐ none

Orthopedic: ☐ painful or swollen joints ☐ muscle weakness ☐ none

Neuro/psych: ☐ tremor ☐ frequent headaches ☐ depression ☐ Anxiety ☐ none

Pain: ☐ Daily pain Where? _____ ☐ none

Over the past 2 weeks have you been bothered by the following? check the best answer

Little interest in doing things?

☐ Not at all ☐ sometimes ☐ more than half the days ☐ nearly every day

Feeling down, depressed or hopeless?

☐ Not at all ☐ sometimes ☐ more than half the days ☐ nearly every day

Please list any other concerns:

Patient Signature:_____Date: _____

Provider Signaure: _____Date:_____