# New Patient Information

Age 16 and above

| Date: | | | |
|---|---|---|---|
| Patient Legal Name (First) | Middle Initial | Last | |
| Nickname (Preferred Name) | Date of Birth | Gender | |
| Email Address | Home Phone # | Cell Phone # | Work Phone # |
| Mailing Address (Street) | City | State | Zip |
| Primary Care Physician | | Employer | |
| Emergency Contact Name | Relationship to Patient | Home Phone # | Cell Phone # |
| Spouse's Name (if applicable) | Email address | Phone # | |

Do we have permission to leave a voicemail message? At home ☐ Cell ☐ Work ☐ No Messages ☐

**To assist with possible physician referrals, please provide the following insurance information:**

| Primary Insurance Company | ID Number | Group Number | Primary Subscriber Name |
|---|---|---|---|
| Primary Subscriber DOB | Phone Number | | |
| Secondary Insurance Company | ID Number | Group Number | Secondary Subscriber Name |
| Secondary Subscriber DOB | Phone Number | | |

The patient or the patient's representative consents to Health by Design using electronic means to obtain the patient's current prescriptions and prescription history.

Signature

## Medical History

**Medications:** *Please list all current medications including over the counter medications and supplements:*

| Medication | Dose | Frequency | Reason |
|---|---|---|---|
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**Allergies:**

| Medication/Food/Latex | Reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

**Other Physicians:**

| | |
|---|---|
| Cardiologist | |
| Gynecologist | |
| Neurologist | |
| Endocrinologist | |
| Rheumatologist | |
| Orthopedic Surgeon | |
| Allergist | |



Name: ______________________________________________________Date of Birth: _______________________________________

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| Gastroenterologist | |
|---|---|
| Other | |

## Medical History

Past Medical History: Check here if no past medical problems ☐

*Please check if you have had, or have any of these medical conditions:*

☐ Acid Reflux/GERD
☐ Allergies (seasonal)
☐ Anemia/blood disorder
☐ Arthritis, general
 ☐ Rheumatoid
☐ Asthma
☐ Bleeding problem
 ☐ Type: ________________
☐ Blood clots
 ☐ DVT (Year: __________)
☐ Pulmonary embolism
 (Year:__________)
☐ Bone density (Year: ________)
☐ Breast feeding
☐ Cancer (Type: _____________)
☐ Cardiac Catheterization
 (Year: ____________)
☐ Cardiac problems
 ☐ Defibrillator
 ☐ Pacemaker
 ☐ Other
☐ Chronic sinus problems
☐ Colonoscopy (Year: _______)
☐ Congestive heart failure
☐ Coronary artery disease
 ☐ Cardiac stents
 ☐ Angina
☐ Coronary artery calcium score
☐ Dermatologic/skin condition
 Type: ____________________

☐ Diabetes
 ☐ Type 1
 ☐ Type 2
 ☐ Unknown
☐ EKG (Year _______________)
☐ Emphysema/COPD
☐ Gastrointestinal bleeding
☐ Gout
☐ Hearing problems/ringing
☐ Hepatitis (Type: ________)
☐ High blood pressure/hypertension
☐ High cholesterol
☐ HIV/AIDS
☐ Insomnia
☐ Irregular heartbeat
 ☐ Palpitations
 ☐ Atrial fibrillation
☐ Kidney disease
☐ Kidney stones
☐ Lupus (SLE)
☐ Mammogram (Year: ________)
☐ Migraines/headaches
☐ Osteoporosis
☐ Overweight
☐ Prostate problems
☐ Psoriasis
☐ PSA (Year: ________)
☐ Psychiatric disorder
 ☐ Anxiety
 ☐ Depression
 ☐ Mood disorder

☐ Rheumatoid arthritis
☐ Sexual/erectile dysfunction
☐ Sexually transmitted disease
 (Name: _________________)
☐ Sleep apnea
 ☐ CPAP
☐ Spinal problems
 ☐ Cervical
 ☐ Thoracic
 ☐ Lumbar
☐ Stress Test (Year: _________)
☐ Stroke (Year: __________)
 (Type: _______________)
☐ Tuberculosis or pos TB skin test
☐ Thyroid disorder or other endocrine disease
 (Name: ______________)
☐ Urinary problems
 ☐ Burning
 ☐ Frequency
 ☐ Incontinence
 ☐ Painful
☐ Vision problems
 ☐ Glaucoma
 ☐ Cataracts
☐ Other: _______________
☐ Other: _______________
☐ Other: _______________
☐ Other: _______________
☐ Other: _______________
☐ Other: _______________



Name: ________________________________ Date of Birth: ______________________

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## Medical History

### Females:

**GYN History**

Date of last menstrual period (if not menopausal) ___________________

Date of last Pap Smear (MM/YYYY) ___________________

Date of last Mammogram (MM/YYYY) ___________________

Menopause year ___________________

**OB History**

Pregnant, Due Date ___________ # vaginal deliveries ______ # C-sections _________

Gestational Diabetes ☐Y ☐N Preeclampsia ☐Y ☐N Delivering baby weighing >9 lbs ☐Y ☐N

### Procedure/Surgical History

Check here if no previous procedures or surgeries ☐

| Name of Procedure | Year |
|---|---|
| | |
| | |
| | |
| | |
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### Most Recent Hospitalizations (reason)

Check here if no hospitalizations ☐

| Hospitalization Reason | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |

### Immunizations

| | Approx. Date | | Approx. Date |
|---|---|---|---|
| ☐ Diphtheria Tetanus (TD) | ______________ | ☐ Influenza | ______________ |
| ☐ Diphtheria/Tetanus/Pertussis | ______________ | ☐ Shingles ☐ Shingrix (2 shots) | ______________ |
| ☐ Hepatitis B | ______________ | ☐ Zostavax | ______________ |
| ☐ Hepatitis A | ______________ | ☐ Pneumonia ☐ Pneumovax 23 | ______________ |
| ☐ HPV (Gardasil | ______________ | ☐ Prevnar 13 | ______________ |
| ☐ Measles/Mumps/Rubella | ______________ | ☐ COVID | ______________ |
| ☐ Meningitis/Meningococcal | ______________ | Manufacturer: ____________ | ______________ |



Name: ______________________________________________ Date of Birth: _________________________________

# Family and Social History

## Family History: Indicate the following:

mother (M) father (F) sibling (S) maternal grandmother (MGM) maternal grandfather (MGF) paternal grandmother (PGM) paternal grandfather (PGF)

☐ _____ Diabetes
☐ _____ Hypertension
☐ _____ Heart Disease
☐ _____ Stroke
☐ _____ Mental Illness
☐ _____ Kidney Disease

☐ _____ Prostate Cancer
☐ _____ Colon Cancer
☐ _____ Breast Cancer
☐ _____ Ovarian Cancer
☐ _____ Other Cancer
☐ _____ Other_______________________________

Father: Alive? ☐Y ☐N Age: _____
Mother: Alive? ☐Y ☐N Age: _____

## Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/widower ☐ Partner

Are you currently smoking/vaping/dipping/e-cigarettes/or chewing? ☐ Y ☐ N

Have you ever smoked/vaped/dipped or chewed? ☐ Y ☐ N

If yes, when did you quit?

☐ <6 mo ago ☐ 6 mo-1.5 yrs ☐ 1.5 yrs-2.5 yrs ☐ 2.5 yrs-3.5 yrs
☐ 3.5 yrs-5 yrs ☐ 5-15 yrs ☐ >15 yrs

Max packs/day? ___________________ Years of tobacco/nicotine use? ______________

Pipes full of tobacco: Per Day ____________ Per Week: ____________

Cigars, cheroots, or cigarillos: Per Day _________ Per Week: ____________

# of water pipe sessions: Per Day _________ Per Week: ____________

# of e-cigarette cartridges: Per Day _________ Per Week: ____________

During the past 12 months did you try to quit smoking? ☐ Y ☐ N

How motivated are you to consider quitting smoking?

☐ Not motivated at all ☐ Somewhat motivated ☐ Seriously considering

Do you drink alcoholic beverages (12 oz beer, 5 ox wine, 1.5 oz hard liquor)? ☐ Y ☐ N

If yes, how many drinks per week? ________________

Do you use recreational drugs? ☐ Y ☐ N If yes, what and how often? ____________________

Do you drink caffeinated beverages such as coffee, tea, or soda on a daily basis? ☐ Y ☐ N

If yes, how much per day? ________________

Do you have a religious practice/preference which may influence healthcare? ☐ Y ☐ N

If yes, please explain? ____________________________________________________________________

Do you exercise regularly? ☐ Y ☐ N If yes, what type, how often, and how long?______
_____________________________________________

Currently working? ☐ Y ☐ N Occupation: _________________________________



Name: _______________________________________________ Date of Birth: __________________________________

# Authorization to Release Protected Health Information

I, ___________________________________________ (patient or legal guardian), authorize Health by Design to release my/patient's protected health information to the following: (Please check and provide the NAME or specific entities to who your protected health information may be given.)

**_____Family Members or Friends:**

Name/Relation: __________________________________________ Phone: _________________________

Name/Relation: __________________________________________ Phone: _________________________

Name/Relation: __________________________________________ Phone: _________________________

Name/Relation: __________________________________________ Phone: _________________________

**_____School or Employer: (list names of school/coach/employer)**

Name/Relation: __________________________________________ Phone: _________________________

Name/Relation: __________________________________________ Phone: _________________________

Name/Relation: __________________________________________Phone: _________________________

I understand that my authorization may be revoked in writing at any time. I understand that my medical record may include information on diagnosis/treatment related to psychiatric or psychological conditions, chemical dependency/alcohol abuse, communicable or infectious diseases. I hereby waive any privilege concerning such information for the purposes(s) of releasing it to the party or parties authorized above.

This Authorization shall be in effect (please check one).

☐ No Expiration Date ☐ Expiration Date of: __________________________________________________

_______________________________________________ ____________________________________

Patient or Legal Guardian Signature Date



Name: ______________________________________________Date of Birth: __________________________