Health by Design
A MEDICI COMPANY

New Patient Information

Age 18 and above

Today's Date: _____

Patient Legal Name (First) *Middle Initial* *Last*

Nickname (Preferred Name) *Date of Birth* *Gender* *Preferred Language*

☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Prefer not to say ☐ Other:

Race

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to say

Ethnicity

Email Address *Home Phone #* *Cell Phone #* *Work Phone #*

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

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 #*

Preferred Pharmacy *Address or nearest major intersection*

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We request insurance information for billing purposes (when applicable), coordination of care, referrals to specialists, and any additional services that may involve third-party providers. This information helps to ensure accurate documentation and continuity of care and may be used for administrative purposes.

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

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Medical History

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

Medication	Dose	Frequency	Reason

Allergies:

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

Are you allergic to Latex? ☐ Yes ☐ No

Other Physicians:

Cardiologist	
Gynecologist	
Neurologist	
Endocrinologist	
Rheumatologist	
Orthopedic Surgeon	
Allergist	
Gastroenterologist	
Other	

Name: _____ Date of Birth: _____

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

Please indicate if you have had or currently have any of the following 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 ☐ 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 (Type: _____) ☐ Sleep apnea ☐ CPAP ☐ Spinal problems ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Stress Test (Year: _____) ☐ Stroke (Year: _____) Type: _____ ☐ Tuberculosis or + TB skin test ☐ Thyroid disorder or other endocrine disease (Name: _____) ☐ Urinary problems ☐ Painful ☐ Burning ☐ Frequency ☐ Incontinence ☐ 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

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: _____	_____

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Family and Social History

Family History: *Indicate next to each condition which family members have a history by using the abbreviations below:*

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: _____)

Children (list age, gender and any health issues) _____
_____

Social and Habits 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 current or previous user:
How many packs per day? _____
How many years of tobacco/nicotine use? _____
When did you start? _____
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
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? ☐ Y ☐ N
If yes, how many drinks per week and what type of alcohol? _____
Do you use recreational drugs? ☐ Y ☐ N
If yes, what type and how often? _____
Do you drink caffeinated beverages such as coffee, tea, or soda on a daily basis? ☐ Y ☐ N
If yes, how many cups (8 oz) per day? _____
Do you have religious practices or preferences affecting your healthcare choices? ☐ Y ☐ N
If yes, please explain? _____
Do you exercise regularly? ☐ Y ☐ N
If yes, what type, how often, and how long? _____
Currently Employed? ☐ Y ☐ N Occupation: _____

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New Patient Information

Age 18 and above

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: _____

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: _____