NorthCity MEDICAL

Office: +347-844-2543
Fax Us: +347-378-8011

NEW PATIENT INTAKE FORMS

Name: _____ **Date**: _____

DOB: _____ **Address**: _____

_____

Phone No.: _____

How did you hear about us? _____

What would you like the medical provider to call you?

_____

Please list how you would like to be contacted for test results: ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Email**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow**

Please list your main reason for making an appointment:

_____

_____

Allergies/Drug Reactions (Please list drug and the reaction):

_____

_____

_____

_____

Please list current medical problems: (List conditions you are currently being treated for)

_____

_____

_____

_____

Please list other medical providers who are also currently treating you:

_____

_____

_____

_____

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Past medical history: (*Please list all hospitalizations, major illnesses and surgeries*)

Who lives with you, in your home? (*Spouse, children, in-laws, significant others, etc.…*)

Occupation:

What are your hobbies?

Birthplace:

Education:

Have you recently traveled outside the U.S.A? (*If yes, where*?)

Do you get regular exercise? (*If yes, describe*)

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Do you wear your seatbelt? ☐ **Always** ☐ **Usually** ☐ **Occasionally** ☐ **Never**

Smoking History

☐ **Never smoked**

☐ **Previous smoker (age started) ____(age stopped) _____**

On average, how many packs a day? _____

☐ **Current smoker (age started) _____**

On average, how many packs a day? _____

Do you drink wine, beer, or other alcoholic beverages? ☐ **Yes** ☐ **No** ☐ **Socially**

If *yes*, how many times in the last year have your consumed 4 or more drinks on one occasion? _____

Have you ever had a drinking problem? ☐ **Yes** ☐ **No**

How many cups of coffee or caffeinated beverages do you consume daily? _____

Do you use: marijuana, cocaine, or any other street drugs/prescriptions not prescribed for you?

☐ **Yes** ☐ **No** (*Leave blank if you would prefer to discuss this with the medical provider*)

Family History

Please be sure to include: cancer, diabetes, high blood pressure, strokes, tuberculosis and other important illnesses

	Age if Living	Age at Death	Health problems/Cause of death
Mother			
Father			
Brothers/Sisters:			
Children:			

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*Please list all medications you are taking, including over the counter medications, vitamins, herbs, and other treatments. Include the name of the Dr. who prescribed it and WHY you are taking it. If you aren't sure on why you're taking the medication, please indicate by writing, "Don't know", if that is the case, please ask your medical provider to explain why and how to use the drug properly. Also, ask about the drugs side effects and what you should do if you experience a side effect.

*Please remember to update your medication list when your medical provider stops, changes or updates your medications. Please bring your medication list with you to medical providers, ER, walk-in clinic visits, nursing home, home health visits and to the hospital. *If you are unable to bring a list with you, please bring your bottles.*

Medication Chart

Medication	Prescribed by	Dose	Frequency	Purpose

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Past Medical History:

Please check whether you have ever had the following:

	Yes	No		Yes	No
Hypertension			Pancreatitis		
Diabetes			Kidney Problems		
Cancer			Abnormal Pap Smear		
Heart Murmur			High PSA (men only)		
Heart Problems			Seizures		
Asthma			Depression/Anxiety		
Emphysema/COPD			Stroke		
Positive skin test for TB			Blood Problems		
Tuberculosis			Thyroid Problems		
Blood Clots			Arthritis		
Asbestos exposure			Radiation treatments to head/neck		
Ulcers			STDs		
Colon Polyps			HIV infection		
Gallbladder Problems			**Other** (**List**):		
Hepatitis/Jaundice					
Liver Problems					

VACCINATIONS	Yes	No	TESTS	Yes	No
Tetanus			Stool cards for colon cancer testing		
Influenza (Flu Shot)			Colonoscopy		
Influenza (H1N1)			Sigmoidoscopy		
Pneumonia			Bone density		
Hepatitis A			Mammogram		
Hepatitis B			Pap Smear (Women Only)		
Shingles			PSA (Men Only)		
Others:			Exam by eye medical provider		

***Please check whether or not you CURRENTLY HAVE, or HAD in the PAST FEW WEEKS:**

	Yes	No		Yes	No
Fatigue			Nausea		
Fever/Chills			Vomiting		
Recent weight change			Abdominal Pain		
Headache			Black Tarry Stools		
Vision Problems			Rectal Bleeding		
Double Vision			Diarrhea		
Blurred Vision			Blood in Urine		

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Eye Pain			Frequent Urination		
Eye Itching			Too much Urine		
Hearing Loss			Getting up at Night to Urinate		
Ear Ache			Pain with Urination		
Ringing in Ears			Excessive Thirst		
Runny Nose			Weakness		
Nose Bleeds			Easy Bruising		
Nasal Congestion			Muscle Aches		
Snoring			Joint Pain		
Hoarseness			Joint Stiffness		
Sore Throat			Swelling in Arms or Legs		
Mouth Sores			Dizziness		
Breast Lump/Pain			Fainting		
Chest Pain			Memory Problems		
Irregular Heart Beat			Numbness		
Pounding Heart Beat			Anxiety/Depression		
Shortness of Breath			Stress		
Cough			Trouble Sleeping		
Wheezing			Hallucinations		
Decreased Appetite			Dry Skin		
Increased Appetite			Itching		
Difficulty Swallowing			Lump or Spot on Skin		
Heartburn			Rash		

MEN ONLY			**WOMEN ONLY**		
	YES	**NO**	Date of last menstrual cycle		
Straining with Urination				**YES**	**NO**
Pain/Lump on Testicle			Pelvic Pain		
Discharge from Penis			Abnormal Vaginal Bleeding		
Prostate Problems			Vaginal Discharge		
Difficulty with Erection			Sexual Difficulties		
Sexual Difficulties					

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GERIATRIC INTAKE

Please Complete if you are *over* 65, or if you have *concerns* about the topics listed below

Do you have medical Durable Power of Attorney for Healthcare? ☐ **Yes** ☐ **No**

(*If yes, please bring a copy*) **Name:** _____ **Relationship:** _____
Do you have a living will? ☐ **Yes** ☐ **No**
(*If yes, please bring a copy*)
Are you afraid of falling? ☐ **Yes** ☐ **No**
Have you fallen in the past year? ☐ **Yes** ☐ **No**
If yes, please tell us about your last fall:
Date: _____
How did this fall happen?

_____
_____
_____
_____

Did you see a medical provider or other professional for treatment after t ☐ **is fall?** ☐ **Yes** **No**
Do you use a walking aid such as a CANE or WALKER? ☐ **Yes** ☐ **No**
Do you drive? ☐ **Yes** ☐ **No**

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We would like to know if you need help with any of the following and who helps you.

TASK	NO HELP	NEEDS HELP	WHO HELPS
Feeding Yourself			
Getting from Bed to Chair			
Getting to Toilet			
Getting Dressed			
Bathing			
Using the Telephone			
Taking your Medications			
Preparing Meals			
Managing finances/checkbook			
Doing Laundry			
Housework			
Shopping for Groceries			
Driving			
Doing Handyman Work			
Climbing a Flight of Stairs			
Getting Places BEYOND Walking Distance			

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