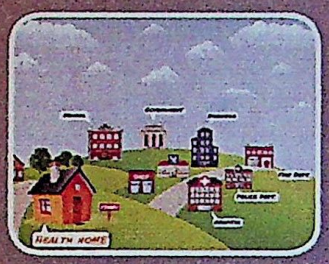
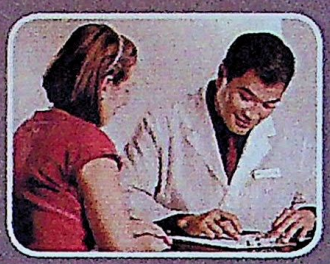
New Patient Forms





Tools to Help You Prepare for Your First Visit to A New Doctor

Washington Health Foundation
#1
HEALTHIEST STATE IN THE NATION CAMPAIGN
www.HealthiestState.org

HEALTH 3.0

You will most likely receive forms similar to the two below, during a first time visit with any health care provider. A first visit to the doctor can be an intimidating experience. Often - you're not feeling well, you're trying to remember your symptoms and your medications, and you're emotional or anxious about your current condition. The Healthiest State in the Nation Campaign has the tools to help guide you through the process.

Use the tool below to prepare yourself for this initial visit and ensure you receive the best care possible by presenting your health care provider with the most comprehensive and up-to-date information. This tool provides two different worksheets. One includes an overview of your personal health history, including lifestyle, allergies, health conditions, hospitalizations, surgeries and medications. The other includes contact information, insurance information, and emergency contact information. Complete the forms and keep them on file in your personal records (save it in your Health Vault or Google Health account, on your personal computer or print it and store it where you save all your personal health information). Print a copy for your health care provider before your first visit so you do not have to worry about trying to remember all of this important information.

Personal Health History

Personal Information:

Name:_____ Date:_____
(Last) (First) (M.I.)

Contact Information:_____

Emergency Contact:_____

Age:_____ Birth date:_____/_____/_____ Gender: Male / Female

Ethnicity/ Race:_____

Occupation(s):_____

Marital Status: Single Partner/Married Widowed

Years of Education/Degree:_____

Do you have children? Yes / No Ages:_____

Who lives with you? _____

Health History:

I have been told I have these diseases or conditions:_____

I have had surgery for:_____ Date:_____

I have been hospitalized for:_____ Date:_____

I am taking these medications:_____ For these health issues:_____
_____ _____
_____ _____

Symptoms and Health Conditions			
HAVE YOU HAD?	Yes/No		Yes/No
Recurrent Headache		Seizures/ Epilepsy	
Vision or Eye Problems		Heart Murmur	
Hearing or Ear Problems		Genetic Disorder	
Autoimmune Disease		Hepatitis	
Cancer		Kidney Disorders	
Thyroid Disorder		Bladder Disorders	
Birth Defect		Bone or Joint Injuries/Issues	
Heart Disease		Stomach Problems	
Heart Palpitations		Intestinal Problems	
High Blood Pressure		Diabetes	
High Cholesterol		Eating Disorder	
Anemia/ Sickle Cell		ADD/ ADHD	
Dizziness/ Fainting with exercise		HIV/AIDS	
Bleeding Disorders: Hemophilia/Other		A Sexually Transmitted Disease	
Head Injury/ Concussion		Alcohol Abuse	
Pneumonia		Drug Abuse	
Seasonal Allergies/Hay Fever		Sexual Assault	
Tuberculosis		Victim of Violence	
Asthma		Mental Health Diagnosis	
Other symptom or condition:		Other symptom or condition:	
Immunizations:		Immunizations Continued:	
Allergies to Medications:		Other Allergies:	

WOMEN'S HEALTH	Yes/No	How Many Times?
Have you been pregnant?		
Have you had an abortion?		
Have you had a miscarriage?		
Have you have an irregular pap smear?		
Have you had breast cancer?		
Age at first period_____ Age at last period_____		

Family History of Health Conditions:

People in my family have had these conditions (name the health condition and the individual's relationship to you):_____

_____

_____

_____

Wellbeing:

How would you rate your general health? Excellent Good Fair Poor

Additional Comments_____

Do you feel that you get enough sleep? Yes / No

Do you feel stressed? Yes / No

Do you feel down? Yes / No

My Pulse is:_____ My Blood Pressure is:_____ My Fasting Blood Glucose is:_____

My Total Cholesterol is:_____ My HDL (good) Cholesterol is:_____ My LDL (bad) Cholesterol is:_____

Caffeine Intake: None Coffee/Tea/Soda: cups/day_____

Weight:

Are you satisfied with your weight? Yes / No Current weight:_____ Current Height:_____

Diet:

How do you rate your diet? Excellent Good Fair Poor

Comments?_____

Exercise:

Do you exercise 30 minutes, 5 times a week? Yes / No

Describe the exercise?_____

Safety:

Do you use a bike helmet? Yes / No / N/A

Do you use a seatbelt? Yes / No

Is violence at home a concern for you? Yes / No

Do you have a gun in the home? Yes / No

Tobacco Use:

Have you used Cigarettes? Yes / No Quit Date:_____ Current Smoker: packs/day_____

Have you used other Tobacco? Yes / No Specify: Pipe Cigar Snuff Chew Quit Date:_____ Currently using? Yes / No

Are you interested in quitting? Yes / No

Alcohol Use:

Do you drink alcohol? Yes: # drinks/week:_____ / No

Drug Use:

Do you use any recreational drugs? Yes / No Drugs:_____

Have you ever used needles to inject drugs? Yes / No

Have you ever misused prescription drugs? Yes / No Drugs misused:_____

Sexual Activity:

Are you sexually active? Yes / No / Not Currently

Current sex partner(s) is/are: Male / Female

Birth control method:_____

Have you ever had any sexual transmitted diseases? Yes / No

Would you like to be screened for one? Yes / No

Patient Information

Please provide the following:

Name:_____ Age:____ Birth Date:__/__/_____
(Last) (First) (MI)

Marital Status: S M D W
(Circle One)

Address:_____

City:_____ Sex: M F
(Circle One)

Employer:_____
(Name) (City)

Home Phone:_____

Who referred you to our office?_____ Soc Security:_____
(Name) (Phone #)

Reason for today's visit:_____

Date of injury or when you first noticed symptoms: __/__/_____ Cause:_____
(if by injury, include where incident occurred)

Primary Insurance:_____
Group #: _____
Subscr.#: _____
If work related, claim #: _____
Ins. Co. Phone#: (___)_____
Ins. Address_____

Secondary Insurance:_____
Group #: _____
Subscr.#: _____
Policyholder Name:_____
Birthdate: _____
Employer: _____
Ins. Co. Phone#: (___)_____

Physician you are seeing today:_____
Family or Primary Care Physician:_____

Financial and Insurance Information (If same as patient, skip to next section)

Primary Insurance
Policyholder:_____ Relation to Patient: _____
(Last) (First) (MI)
Home Phone: _____
Birthdate:__/__/_____ Soc Security#_____
Address:_____ City:_____ State:_____ Zip:_____
Employer:_____ Work Phone: (___)_____
(Name) (City)

Person to Contact in Case of Emergency

Next of Kin:_____ Home Phone:_____
(or legal guardian, if same as primary insured, note same)

Relationship to Patient:_____ Work Phone:_____
Emergency Contact:_____ Home Phone:_____
Relationship to Patient:_____ Work Phone:_____

The medial facility may request the following information to include as part of your medical record:
Advance Directives: Do you have a living will? Yes___ No___
Do you have a Healthcare Power-of-Attorney? Yes___ No___
Religion: If you would like it included in your record, what is your religious preference?_____