NEW PATIENT FORM

Providence Medical Group--Gateway
Internal Medicine

Full Name: _____ Preferred Name: _____

Date of birth: _____ Birthplace: _____

Raised: _____

Past Primary Care Physician (including last date): _____

Other Medical Providers/Doctors that you see: _____

_____

Relationship Status

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Other _____

Number of people in household: _____

Education/Work

Highest level of school completed: _____

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Current Job (if applicable): _____ Number of hours per week: _____

Medications

Allergies:

□ Yes □ No

Name(s), if applicable: _____ Reaction: _____

_____ Reaction: _____

Current Medications:

(List any medication you are currently taking, including over-the-counters, herbs, supplements, etc.)

Name	***Dose/Frequency***	***How long have you been taking?***

Routine Health Screenings
(Check if you have had and write in last date and if abnormal in the blank, not all will be applicable.)

□ Cholesterol/lipids: _____

□ Blood sugar/diabetes: _____

□ STD/HIV/Hepatitis B/C check: _____

□ History of childhood abuse/stressful events that you would like to discuss: _____

□ Do you feel **UNsafe** in your home currently: _____

□ Colonoscopy/stool blood test/colon cancer screening: _____

□ Pap/cervical cancer screening (*females* only): _____

□ Mammography/breast cancer screening (*females* only): _____

□ Osteoporosis scan/bone density test (over 65): _____

Immunizations

Have you had:
□ TDaP (Tetanus, Diphtheria, Pertussis/whooping cough in last 10 years)
□ Pneumonia (e.g. Pneumovax/Prevnar)
□ Shingles (60 and older)

Personal Medical History

Please list **CURRENT/PRESENT** medical conditions/diagnoses that you know about:

_____

_____

_____

Please list **PAST** medical conditions/diagnoses you feel would be important for your doctor to know:

_____

_____

Previous **Operations/Surgeries**:

Type	***Year***

Habits/Social History

Caffeine: ☐ No ☐ Yes: What kind/How much per day? _____

Tobacco/Nicotine: ☐ Never ☐ Past/Former: Quit date? _____

☐ Yes: Type (Cigarettes, smoke, chew, cigars, e-cigarette/vape, etc)? _____

How much a day: _____ Since (years): _____

Alcohol: ☐ None ☐ Yes: How many drinks/day? _____ Frequency/week: _____ What kind: _____

Recreational drugs (e.g. marijuana/cocaine/meth/heroin): ☐ None ☐ Past/Former: Quit date? _____

☐ Yes: Type & how often? _____

Sexually active: ☐ No

☐ Yes: with ☐ Men ☐ Women ☐ Both

Method of birth control/safer sex (if applicable): _____

Family History

Father: Living? _____ Known health problems: _____

Mother: Living? _____ Known health problems: _____

Number of brothers: _____ Number living: _____ Number deceased: _____

Number of sisters: _____ Number living: _____ Number deceased: _____

Number of children: _____ Number living: _____ Number deceased: _____ Ages: _____

Significant/serious family-related health conditions, if known (e.g. cancer, high blood pressure, diabetes):

_____

Symptom Checklist
(Review this list of symptoms and please check if you have had persistent problems with them within the *last 1-2 months*.)

General:
□ Fevers/Chills/Sweats
□ Weight loss/gain
□ Fatigue
□ Other: _____

Eyes:
□ Eye pain
□ Change in vision
□ Other: _____

Ears/Neck/Throat:
□ Change in hearing
□ Ringing/Tinnitus
□ Swollen glands/lymph nodes
□ Difficulty swallowing
□ Sore throat
□ Other: _____

Lungs/Respiratory:
□ Shortness of breath
□ Cough
□ Wheezing
□ Other: _____

Heart/Cardiac:
□ Chest pain
□ Palpitations/Fast heart rate/Irregular heart rate
□ Leg swelling/Edema
□ Other: _____

Stomach/Digestive Tract/Gastrointestinal:
□ Heartburn
□ Nausea/Vomiting
□ Diarrhea
□ Constipation
□ Blood in stool
□ Other: _____

Muscles/Bones/Musculoskeletal:
□ Back pain □ Shoulder pain
□ Neck pain □ Hand pain
□ Knee pain □ Hip pain
□ Other: _____

Urinary/Genitourinary:
□ Pain with urination
□ Blood in urine
□ Frequent nighttime urination
□ Urinary frequency/urgency
□ Discharge (vaginal/penile)
□ Sexual difficulties
□ Vaginal bleeding after menopause
□ Other: _____

Skin/Dermatologic:
□ Rash
□ Change in moles
□ Other: _____

Hormones/Endocrine:
□ Always cold/hot
□ Thirsty/drinking a lot of water
□ Hair thinning/loss
□ Other: _____

Head/Neurologic:
□ Headaches/Migraines
□ Memory changes
□ Numbness/tingling
□ Other: _____

Mood/Psych:
□ Change in mood
□ Depressed
□ Anxious
□ Trouble with sleeping/insomnia
□ Other: _____