NEW PATIENT INFORMATION

Name: _____ DOB: _____ SS#: _____

Address: _____ Cell Phone: _____

State: _____ Zip: _____ Home Phone: _____

Gender: _____ Race: _____ Work Phone: _____

Insurance Company:_____

Name of Insured:_____ ID#_____

Insured's DOB: _____ Group #: _____

Insured's relationship to you: _____

HSA or Reimbursement Account?: _____

Emergency Contact: _____ phone #_____

Relationship:_____

List of Individuals with whom you give permission to discuss your medical information:

_____

For New OMM Consult Patients:

Primary Care Physician:_____ Referred by:_____

For New Family Medicine Patients:

Previous PCP:_____

How did you hear about us?_____

Signature: _____ Date: _____

Name: _____ DOB: _____

REASON FOR VISIT:

_____
_____
_____
_____
_____

When did it start?

_____

How did it start?

_____
_____

How has it changed?

_____

What has been attempted to improve symptoms so far?

_____
_____

What makes it worse?

_____
_____

If you have pain related to the reason you're here, please describe how it feels:

_____
_____

Please share any ideas/concerns you have about your problem and any expectations you have about your visit today:

_____
_____
_____

PAST and OTHER CURRENT MEDICAL PROBLEMS (ex. heart disease, diabetes, thyroid disease):

_____
_____
_____
_____
_____

Signature: _____ Date: _____

Name: _____ DOB: _____

SURGERIES (include year): _____
_____
_____

TRAUMA HISTORY (include personal birth history, car accidents, broken bones, concussions and year):
_____
_____
_____

MEDICATIONS (include dosage and frequency taken per day):_____
_____
_____
_____
_____

SUPPLEMENTS: _____
_____
_____
_____
_____

ALLERGIES (Medication/Food/Environmental): _____
_____
_____
_____

FAMILY HISTORY:
Mother: _____
Father: _____
Other (relationship and medical issue):_____
_____
_____

SOCIAL HISTORY:
Occupation: _____
Relationship status (circle): Single, Married, Partnered, Widowed, Separated, Divorced
Hobbies: _____
Tobacco use: (include type & #pack/day, year quit): _____
Alcohol use (#/week):_____ marijuana use (how often?): _____
Caffeine: (type & #/day): _____ other drug use: _____
Exercise (circle): None, Occasional, 1-2 times/week, >3 times/week:_____

Signature: _____ Date: _____

Name: _____ DOB: _____

CURRENT SYMPTOMS (please circle all that apply)

fever, chills, fatigue/lethargy, difficulty sleeping, night sweats, unintentional weight changes, decreased appetite
hot flashes, intolerance to heat/cold
passing out, sensation of spinning, headaches, seizures, trouble with walking, changes in balance, new bowel/bladder incontinence
numbness, tingling, weakness
joint stiffness, joint pain, osteoporosis, joint swelling/redness, changes in range of motion
eye pain, vision changes, eyeglass/contact use, double vision, teary/gunky eyes, eye redness
ear pain, ear pressure, changes in hearing, multiple ear infections
sneezing, runny nose, stuffy nose, itchy eyes, allergies, sinus problems
sore throat, dental problems, jaw pain, swollen neck, enlarged glands
chest pain or pressure, changes in sensation of heartbeat, leg swelling
Shortness of breath with/without exercise, coughing, sputum, coughing blood, pain with breathing, asthma, wheezing
diarrhea, constipation, nausea, vomiting, heartburn, trouble swallowing, blood in stools, black stools, abdominal pain
nighttime urination, blood in urine, bladder control problem, pain with urination, trouble starting/stopping urination, urinary frequency, kidney stones
ovarian cysts/fibroids pain with intercourse, PMS, heavy / painful periods, sexual problems
easy bruising, easy bleeding, anemia, blood clots
anxiety, stress, depression, inattention, behavioral problems, learning problems, psychological problems

Signature: _____ Date: _____

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