New Patient Form

Name *

First Name Last Name

Date of Birth *

Month Day Year

Email *

example@example.com

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Please enter a valid phone number.

Alternate Number

Please enter a valid phone number.

Referred by:

Insurance

Primary Insurance

	Answer
Insurance Company	
Policy Number	
Subscriber's Name	
Subscriber's D.O.B	

Secondary Insurance

	Answer
Insurance Company	
Policy Number	
Subscriber's Name	
Subscriber's D.O.B	

Tertiary Insurance

	Answer
Insurance Company	
Policy Number	
Subscriber's Name	
Subscriber's D.O.B	

Doctor Information

	Primary Care Physician	Endocrinologist
Doctor's Name		

Last Visit		
Phone Number		
Fax Number		

Please describe your problem (include date of injury if applicable)

Local Pharmacy Information

Local Pharmacy Name

Pharmacy Phone Number

Please enter a valid phone number.

Pharmacy Fax Number

Pharmacy Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Past Medical History

Check all that apply

- ☐ Frequent Headache / Migraine
- ☐ Kidney Disease
- ☐ COPD
- ☐ Stroke
- ☐ Gout
- ☐ Tumor / Abnormal Growth / Cancer
- ☐ Anemia / Blood Disorders
- ☐ Epilepsy / Seizures
- ☐ Gastrointestinal
- ☐ High Blood Pressure
- ☐ Psychiatric Treatment
- ☐ Prostate Disorder
- ☐ Autoimmune Disease (RA, lupus, scleroderma, polymyalgia rheumatica, etc.).
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Heart Trouble
- ☐ Chest Pain or Mild Exertion
- ☐ Blood Clots
- ☐ Ear / Nose / Throat Disorder
- ☐ Drug / Alcohol Abuse
- ☐ Bleeding Disorders
- ☐ Thyroid / Parathyroid Disease
- ☐ Arthritis
- ☐ Asthma / Hay Fever / Shortness of Breath
- ☐ Sexually Transmitted Disease
- ☐ Diabetes
- ☐ _____

Has any FAMILY MEMBER had any of the following problems (Please indicate relationship)

Patient Information

Do you currently smoke?

- ○ Yes
- ○ No

Smoke previously?

- ○ Yes
- ○ No

Year quit?

Number of caffeinated drinks per day

Amount of alcohol consumed per week

Please complete the following:

Height

Weight

Shoe Size

Occupation

Marital Status:

- ○ Single
- ○ Married
- ○ Divorced
- ○ Widowed
- ○

Allergies

Please check all allergies:

- ☐ Medications
- ☐ Foods
- ☐ Tapes
- ☐ Novocain
- ☐ Anesthetics
- ☐ Silver / Nickel / Costume Jewelry
- ☐ _____

Health Review

Please select any symptoms you have had in the past 3 months

General

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ _____

Head

- ☐ Headaches
- ☐ Visual Problems
- ☐ Hearing Problems
- ☐ Light Sensitivity
- ☐ _____

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Swelling of legs
- ☐ _____

Hematology

- ☐ Anemia
- ☐ Abnormal Bleeding / Bruising
- ☐ Blood Clots
- ☐ _____

Respiratory

- ☐ Persistent cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ _____

Gastrointestinal

- ☐ Difficulty Swallowing
- ☐ Indigestion / Heartburn
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ _____

Urinary

- ☐ Painful Urination
- ☐ Frequent Night-time Urination
- ☐ Bladder Leakage
- ☐ _____

Musculoskeletal

- ☐ Joint Pain / Swelling / Stiffness
- ☐ Back Pain
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ _____

Skin

- ☐ Skin Rash
- ☐ Suspicious Lesions
- ☐ Itching
- ☐ _____

Neurological

- ☐ Numbness of hands/feet
- ☐ Seizures
- ☐ Tremors
- ☐ Paralysis
- ☐ _____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Problems Sleeping
- ☐ Memory Loss
- ☐ _____

Endocrine

- ☐ Heat / Cold Intolerance
- ☐ Hot Flashes
- ☐ Change in hair / skin texture
- ☐ _____

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail, or phone by either physician or hospital. Also, I hereby authorize the doctor or her assistants to initiate the diagnosis and treatment of my condition with x-ray, examination, or photographs of infections as necessary.

Date

Month Day Year

I have personally reviewed the above information:

Date

Month Day Year