NEW PATIENT INFORMATION

Name: ____

Address: ______________________________________

City: ____________________ Zip: ______________

Home Phone: __________________________
Work Phone: __________________________

For Office Use
Date Called: __________________
Appt Date & Time: ______________
Dr Seeing: ____________________
Type of insurance: ______________
Secondary Insurance: ____________
Medical Records: bring ___ fax ___ mail ___
Reason for referral:
____
Office: Grosse Pointe Woods Utica
Referring Physician: ______________

Social Security #: ______________________
Date of Birth: ____________________
Marital Status: Married Single Widowed Divorced
Sex: Male Female
Occupation: ____________________
Employer: _______________________

Please verify that the above information is correct then complete the remainder of the outpatient information form.

How were you referred to our office?

_____ Primary Care Physician
_____ Surgeon or Sub-specialist
_____ Friend or Family Member
_____ Insurance Plan
_____ Other (Please specify ____________________)

Emergency Information:

Contact Person: ____________________________________
Relationship: ______________________________________
Home Phone: ( )_________________ Work Phone: ( )__________________

Hospital of Preference:

Bon Secours Cottage St John St Joe's West

Persons with whom we may discuss your care:

Name	Relationship	Phone

Name of your Primary Care Physician: ______________________________

Names of other physicians that you see and would like reports sent to:

Name	Specialty	Phone Number

Medication Information

Medications/vitamins/herbal meds that you are currently taking

Medications/Vitamins	Dose	How many times a day taken

Pharmacy Name: ____

Pharmacy Number: ( )___________________________

Do you have prescription coverage? Yes ___ No ___

Do you have a prescription copay? Yes ___ No ___ Amt: $____

Allergies:

Drug	Reaction

Have you had any surgeries?

Type of Surgery	Date (approximate)

Please check off whether you currently have or have experienced any of the following problems in the past.

____	Heart attack	____	Thyroid Disease	____	Irregular Heart Beat
____	Chest Pain	____	High Cholesterol	____	Emphysema
____	Stroke	____	Depression	____	Asthma
___	Diabetes	____	Heart Failure	____	Stomach Ulcer
____	High blood pressure	____	Tuberculosis	____	

Name: ________________________________

Habits:

Do you drink alcohol? Yes ___ No ___

What type?
- ___ Beer
- ___ Wine
- ___ Liquor (type______________)

How many at a time?

1-2 ___ 3-5 ___ >5 ___

How often?
- ___ Daily
- ___ Weekly
- ___ Monthly

Do you use tobacco? Yes ___ No ___

What type?
- ___ Cigarettes
- ___ Chewing tobacco
- ___ Pipe
- ___ Cigar

How much per day? ____________

For how many years? ____________

Are you a former smoker? Yes ____ No ____

What? __Cigarettes ___Pipe ___Cigar

How many packs per day? _____

How long ago did you quit smoking? ______

Do you or did you ever use drugs? Yes ___ No ___

What type? ______________________________

When? __________________________________

Home Situation:

Who do you live with?
- ____ Spouse
- ____ Parents
- ____ Children (Names: ___________________________)
- ____ Self
- ____ Other

Are you on disability? ___ Yes ___ No

Reason: ____________________________

When? _____________________________

Family History

Relation	Alive	Deceased	Age	Cause of Death
Mother				
Father				
Sib (bro/sis)				
Sib (bro/sis)				
Sib (bro/sis)				
Child				

Have any of your blood relatives had:

Cancer Yes ____ No ____ Who ______________________________

Tuberculosis Yes ____ No ____ Who ______________________________

Diabetes Yes ____ No ____ Who ______________________________

Heart Attack Yes ____ No ____ Who ______________________________

High Blood Pressure Yes ____ No ____ Who ______________________________

Stroke Yes ____ No ____ Who ______________________________

Bleeding Disorder Yes ____ No ____ Who ______________________________

Anemia Yes ____ No ____ Who ______________________________

Name: ____

Please check off whether you currently have or have experienced any of the following problems in the past.

General

- ____ Fatigue
- ____ Weight loss
- ____ Weight gain
- ____ Change in appetite
- ____ Fevers
- ____ Night sweats
- ____ Swollen glands

Eyes

- ____ Blurred vision
- ____ Cataracts
- ____ Wear glasses or contacts
- ____ Double vision
- ____ Glaucoma

Ears & Nose

- ____ Decreased hearing
- ____ Infection
- ____ Nose bleeds
- ____ Use hearing aid
- ____ Ringing
- ____ Sinus problems

Mouth & Throat

- ____ Wear false teeth
- ____ Hoarseness
- ____ Pain on swallowing
- ____ Sores
- ____ Difficulty swallowing

Chest/Heart/Lungs

- ____ Cough
- ____ Wheezing
- ____ Heart Murmur
- ____ Shortness of breath
- ____ Coughing blood
- ____ Palpitations
- ____ Leg swelling

Gastrointestinal

- ____ Nausea/vomiting
- ____ Constipation
- ____ Abdominal pain
- ____ Blood in stools
- ____ Diarrhea
- ____ Hemorrhoids
- ____ Tarry stools

Urinary

- ____ Blood in urine
- ____ Decreased stream
- ____ Loss of control
- ____ Up at night
- ____ Stones
- ____ Infection
- ____ Burning
- ____ Discharge

Neurologic

- ____ Numbness/tingling
- ____ Weakness in arm or leg
- ____ Dizziness
- ____ Slurred speech
- ____ Headaches
- ____ Seizures
- ____ Blackouts

Reproductive (Male)

- ____ Prostate problems
- ____ Impotence

Reproductive (Female)

- ____ Irregular periods
- ____ Vaginal bleeding
- ____ Menopause
- ____ Breast lump

Skin

- ____ Moles
- ____ Rash
- ____ Sores
- ____ Skin Cancer

Bones & Joints

- ____ Arthritis
- ____ Back pain
- ____ Walk with cane or walker
- ____ Gout
- ____ Fractures

Name: ________________________________

*****PLEASE NOTE: In order for the office to be able to fill the appointment time that you will not be able to use, we require a 24-hour notice for missed appointments. If you DO NOT call and cancel your appointment, there will be a $20 missed appointment fee assessed to you the patient. *****

Thank you.

Revised 2/2002 cm