Requested PCP:

CORE PHYSICIANS
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# NEW PATIENT INFORMATION

**Date:** _____ **How did you hear about us:**

## Demographics

Last Name: First Name: MI:
Previous Last Name: Preferred Name:
Address:
City/State/Zip:
Home Phone: Cell Phone: Work Phone:
Email:
Date of Birth: Birth Sex: Gender:
Legal Status: ☐ Self ☐ Legal Guardian If self, continue to Advance Directives.
Name: Contact Info:
Surrogate Exp. Date
Name: Contact Info:
Paperwork on file: ☐ Yes ☐ No

Advance Directives: ☐ Yes ☐ No If yes, please bring a copy with you to your first appointment.

Emergency Contact Name: Home Phone:
Relationship: Cell Phone:

## Social History

**Tobacco – Smoking Status**

Use Tobacco: ○ Current ○ Former ○ Never
How many smoked per day?
What age did you start smoking?
Passive Smoke Exposure? ☐ Yes ☐ No
Tobacco Cessation Attempts? ☐ Yes ☐ No

**Alcohol**

Drink Alcohol? ○ Yes ○ No ○ Formerly
Frequency: ○ Daily ○ Weekly ○ Monthly ○ Occasionally ○ Rarely ○ Socially

**Caffeine:** ○ Coffee ○ Soda ○ Energy Drinks ○ Tea Cups Per Day:

## Marital Status | Family | Social Support

Current Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Life Partner ○ Legally Separated
Children: Number of Sons: Number of Daughters

## Education | Employment | Occupation | Military Service

Primary Language Spoken: Language Spoken at Home:
Country of Birth: Hand Dominance: ○ Right ○ Left ○ Ambidextrous
Education: ○ Elementary ○ High School ○ College ○ GED ○ Tech School Degree Obtained
Employer: Occupation:
Retire Year: Military Experience: ☐ Yes ☐ No

**Lifestyle** ○ Moderate ○ Sedentary ○ Vigorous Changes in Sleep Patterns? ☐ Yes ☐ No
Health Club Member? ○ Now ○ Previously ○ Never
Type of Exercise | Frequency: Animals in Home? ☐ Yes ☐ No

## Home Environment | Safety

Smoke Detectors In Home? ☐ Yes ☐ No Pool/Spa at Home? ☐ Yes ☐ No Home Heating:
Carbon Monoxide Detectors in Home? ☐ Yes ☐ No Firearms at Home? ☐ Yes ☐ No Use Seat Belt? ☐ Yes ☐ No
Radon in Home? ☐ Yes ☐ No ☐ Treated ☐ Untested Use Bike Helmet? ☐ Yes ☐ No

For Office Use Only: Do NOT scan into ICS.



Fax form to 603-580-6644

| Patient Name: | | Date of Birth: | |
|---|---|---|---|

## Medical & Surgical History

| Year: | Description of Disease, Condition or surgery: | Year: | Description of Disease, Condition or surgery: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Family History (Blood Relative)

☐ Patient Adopted

| Family Member | Age | Diagnosis - Use list below and write in all that apply: |
|---|---|---|
| Mother | | |
| Father | | |
| Sister | | |
| Sister | | |
| Sister | | |
| Brother | | |
| Brother | | |
| Brother | | |
| Other Relative | | |

**Use these terms as applicable:**

| | | | | | |
|---|---|---|---|---|---|
| Alive & Well | Asthma | CVA (Stroke) | Hearing Deficiency | Mental Illness | PVD |
| Add/ ADHD | Blood Disease | Depression | Hyperlipidemia | Migraines | Renal Disease |
| Alcoholism | CAD | Developmental Delay | Hypertension | Obesity | Seizure Disorder |
| Allergies | CAD-Premature | Diabetes | Irritable Bowel (IBS) | Osteoarthritis | Osteoporosis |
| Alzheimer's Disease | Cancer | Eczema | Learning Disability | | Other |

## Medication(s)

| Medication Name | Dose | | Medication Name | Dose |
|---|---|---|---|---|
| | | | | |
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| | | | | |

**Pharmacy Name & Location:**

## Allergies

☐ No Known Allergies

**Include food and drug allergies and adverse reactions**

| Ingredient \| Allergen | Brand Name | Reaction |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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## Specialty Physicians

Specialist Seen (i.e., ob-gyn, cardiologist, orthopedist)

| | |
|---|---|
| Specialty: | Specialist Name: |
| City, State: | Phone Number: |

| | |
|---|---|
| Specialty: | Specialist Name: |
| City, State: | Phone Number: |

| | |
|---|---|
| Specialty: | Specialist Name: |
| City, State: | Phone Number: |

| | |
|---|---|
| Specialty: Dentist | Specialist Name: |
| City, State: | Phone Number: |

| | |
|---|---|
| Specialty: Ophthalmologist *(Eye Doctor)* | Specialist Name: |
| City, State: | Phone Number: |

To fax form please save, print and fax to 603-580-6644.

PRINT