WASHINGTON HEALTH SYSTEM
Infectious Disease

New Patient Information Form

Date_____

Personal Information

Who referred you to our office_____

Last Name_____First _____MI _____

Street Address_____

City _____ State_____ Zip Code_____

Home Phone _____ Cell Phone _____

Work Phone_____ Email Address _____

SSN # _____Birth Date _____ Sex M / F Married / Single / Divorced / Widowed

Optional *- We encourage you to voluntarily provide the following, on racial background and ethnicity.*

() Am Indian/Alaskan Native () Asian () African American () Caucasian () Hawaiian/Pacific Islander () Hispanic/Latino
() Not Hispanic/ Latino () Other

Work Status () Employed () Unemployed () Retired () Student If you are a student are you () Full Time () Part Time

Occupation _____ Employer _____

Emergency Contact_____ Emergency Phone _____

Relationship to Patient_____

Pharmacy Name _____ Phone_____

Family Doctor _____ Phone_____

Financial Responsibility *(patient's under 18)*

Name_____ Birth Date _____ SSN # _____

Address (If different then patient) _____

Home Phone _____ Cell Phone _____

Work Phone_____ Email Address _____

Reason for today's visit _____

_____

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Current Medication Records

List all medications you are currently taking, include over-the-counter drugs (aspirin, Tylenol, vitamins and herbal supplements)

Prescription	Dosage	Reason

Past Medical History

Check all that apply

- ☐ Abnormal Pap Smear
- ☐ Allergic Rhinitis (Nasal Allergies)
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (Enlarged Prostate)
- ☐ Bronchitis-Chronic
- ☐ Cancer
- ☐ Cardiomyopathy
- ☐ Colon Polyps
- ☐ COPD (Lung Disease)
- ☐ CVA (Stroke)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (Insulin Dependent)
- ☐ Diabetes (Non-Insulin Dependent)
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ GERD (Heartburn)
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Migraine Headaches
- ☐ Hepatitis
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypothryoidism
- ☐ Irritable Bowel Disease
- ☐ Kidney Disease
- ☐ Lumbar Stenosis
- ☐ Low Back Pain
- ☐ Menopausal Symptoms
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Peptic Ulcer Disease
- ☐ PVD (Vascular Disease)
- ☐ Rheumatoid Arthritis
- ☐ RLS (Restless Leg Syndrome)
- ☐ Sexually Transmitted Disease
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ C-Section
- ☐ Tubal Ligation
- ☐ Other (Please specify)

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Surgery History

Check all that apply and year (if known)

- ☐ Amputation (Please specify) Year _____
  _____
- ☐ Appendectomy Year _____
- ☐ Arthroscopy (Please specify) Year _____
  _____
- ☐ Breast Lumpectomy Year _____
- ☐ Bypass in Leg Year _____
- ☐ Cardiac Bypass Year _____
- ☐ Cardiac Cath Year _____
- ☐ Cataracts Year _____
- ☐ Colon Resection Year _____
- ☐ Colonoscopy Year _____
- ☐ Cystoscopy Year _____
- ☐ Endoscopy Year _____
- ☐ Gall Bladder Removal Year _____
- ☐ Gastric Bypass Year _____
- ☐ Hernia Repair Year _____
- ☐ Hip Replacement Year _____
- ☐ Hysterectomy Year _____
- ☐ Knee Replacement Year _____
- ☐ Lap Band Year _____
- ☐ Ovary Removal Year _____
- ☐ Pacemaker Year _____
- ☐ Prostate Surgery Year _____
- ☐ Stent – Heart Year _____
- ☐ Stent – Kidney Year _____
- ☐ Stent – Leg Year _____
- ☐ Tonsils Year _____
- ☐ Tubes in Ears Year _____
- ☐ Vasectomy Year _____
- ☐ Other (Please specify) Year _____
  _____
  _____
  _____

Family Medical History

Has any family member/relative had the following

Illness/Type	Family Member/Relative
☐ Cancer: Breast	
☐ Cancer: Colorectal	
☐ Cancer: Ovarian	
☐ Cancer: Prostate	
☐ Cancer: Other	
☐ High Blood Pressure	
☐ Heart Disease	
☐ Diabetes	
☐ Stroke	
☐ Depression	
☐ Anxiety	
☐ Glaucoma	
☐ Alcohol Abuse	
☐ Drug Abuse	
☐ Thyroid Disease	
☐ Rheumatoid Arthritis	
☐ Other	
☐ Other	

Allergies

List all known allergies

_____

_____

_____

_____

Social Habits

Have you ever used tobacco products? () Yes () No

What kind_____ How much _____How many years _____

Have you ever used tobacco products? () Yes () No

Intensity () Socially () Daily () Weekly

Have you ever used drugs? () Yes () No

What kind_____ How much _____How many years _____