WELCOME NEW PATIENTS!

Thank you for choosing

WASHINGTON HEALTH SYSTEM
Family Medicine - North Main

Please arrive 20 minutes prior to your appointment time.

Please wear a mask if you are experiencing cold or flu-like symptoms.

Free parking is available behind the building. Drive up to the gate and it will open.

Please bring the following items to your appointment:

- ✓ Completed new patient paperwork
- ✓ Insurance card(s) including Medicare card if applicable

  If your insurance card lists a PCP or specific practice name, this must be changed to Family Medicine North Main or the name of your new Family Medicine North Main PCP* ***before your appointment *. Otherwise, your insurance company may not pay for your visit, and you may receive a bill.*
- ✓ Photo ID or driver's license
- ✓ Current medication list
- ✓ Previous medical records, if available

- If you No-Show for your new patient appointment, you will not be rescheduled.
- If you arrive late, your appointment will be rescheduled.
- Please call 24 hours in advance if you need to reschedule your visit.

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No Show Policy Addendum

Please be aware that in addition to the information noted on the Cancellation and No-Show Appointment Policy, our office requires patients to cancel their appointments **no later than 2 hours prior to their scheduled appointment time.**

Your courteous call 2 hours in advance enables us to schedule other patients with acute issues who need care.

Appointments not cancelled within the 2 hour timeframe noted above will be considered no-show appointments.

Patient Name (please PRINT) _____ Today's Date _____

Patient Signature (or authorized representative) _____ Relationship _____

NEW PATIENT INFORMATION

WASHINGTON HEALTH SYSTEM
Family Medicine - North Main

Name_____ DOB ___/___/___
Address_____ City _____State ____ Zip_____

If patient is a minor:
Mother's full name _____Father's full name_____
Legal guardian's full name (if not mother or father)_____
Primary insurance holder for patient_____

Briefly describe your top 3 concerns today:
1)_____
2)_____
3)_____

Please list all prescriptions, over the counter medications and vitamins.

NAME OF DRUG	DOSE

Drug allergies:_____
Preferred pharmacy:_____

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Please list previous surgeries. Name_____ DOB___/___/___

TYPE OF SURGERY	YEAR	REASON

Past medical history – please check all that apply.

	Aids / HIV		Drug Abuse		Pacemaker
	Alcohol Abuse		Eczema		Palpitations
	Allergies		Enlarged Prostate		Pneumonia
	Asthma		Fibromyalgia		Psoriasis
	Anemia		Gallbladder Disease		Sciatica
	Anxiety		GERD (Reflux)		Seizures
	Arthritis		Glaucoma		Sexual Dysfunction
	Atrial Fibrillation		Gout		Sleep Apnea
	Back Pain		Headaches		STD
	Blood Clots		Heart Attack		Stomach Ulcer
	Cancer		Heart Disease		Stroke
	Chest Pain		Heart Murmur		Swollen Ankles
	Congestive Heart Failure		Hemorrhoids		Thyroid Disease
	Constipation		Hepatitis C		Tuberculosis
	COPD		High Blood Pressure		Ulcerative Colitis
	Crohn’s Disease		High Cholesterol		UTI (Recurrent)
	Depression		Kidney Stones		Other:
	Diabetes Mellitus-Type I		Kidney Disease (Renal Insufficiency)		Other:
	Diabetes Mellitus – Type II		Liver Disease		Other:
	Diverticulitis		Osteoporosis		Other:

Name_____ DOB___/___/___

Do any family members have a history of the following:

ILLNESS	FAMILY MEMBER	AGE OF ONSET	ALIVE	DECEASED

Please answer the following questions related to safety.

Do you wear a seat belt?		
Are you exposed to secondhand smoke?		
Do you drink caffeinated beverages?		
Have you had 2 or more falls in the past year?		
If there is a gun in your home, is it stored unloaded in a secure location away from children?		
Are you in a verbally or physically abusive relationship?		
Do you feel safe in your home?		

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Name_____ DOB___/___/___

Please answer the following questions regarding your personal history.

What is your highest education level? Grade_____ Please check: Some College_____ College Graduate_____ Advanced Degree_____
Do you have children? No_____ Yes _____ If yes, how many? _____
How often do you exercise each week? No exercise _____ 1-2 x per week_____ 2-3 x per week_____ 3-4 x per week_____
What kind of exercise?
With whom do you currently live?
Marital status: Partner/Significant other _____ Never married _____ Married _____ Divorced _____ Separated _____ Widowed _____
Are you currently working? No _____ Yes_____
What is your current or past occupation?

Please answer the following questions about your social history.

Are you a smoker? No _____ Yes _____
CURRENT SMOKER: How many cigarettes/ cigars per day? Please check: 5 or less _____ 6-10_____ 11-20 _____ 21-30_____ 31+ _____
FORMER SMOKER: How long ago did you quit smoking?
Please list any other tobacco use:
Are you sexually active? Yes _____ No _____ My partner preference is: Male _____ Female_____ Both _____
Did you have a drink containing alcohol this year? No _____ Yes _____
If yes, how often do you drink alcohol? Please check: Monthly or less _____ 2-4 per month _____ 2-3 per week 4 + per week _____
How many drinks on a typical day? Please check: 1-2 _____ 3-4_____ 5-6_____ 7-9_____ 10+ _____
How often have you had 6 or more drinks on one occasion? Please check: Never _____ Less than monthly _____ Monthly _____ Weekly _____ Daily _____
Do you use drugs that are not medical? No_____ Yes _____
If yes, please list any non-medical drugs:

Name_____ DOB___/___/___

Please answer the following questions regarding your mood.

In the past 2 weeks, do you report:
Little interest or pleasure in doing things? Yes _____ No_____
Feeling down, depressed or hopeless? Yes _____ No_____

Please answer the following questions if you are age 65+

Have you had 2 or more falls in the past year? Yes _____ No_____
FEMALES ONLY:
Do you have urinary leakage when you laugh, cough or sneeze?
Yes _____ No_____
Do you ever have loss of bladder control? Yes _____ No _____

Please answer the following questions about your health maintenance.

MALES ONLY: When was your last:	Date
Prostate Exam	
Colonoscopy	
PSA Test	
Flexible Sigmoidoscopy	
Hemoccult Cards	

FEMALES ONLY: When was your last:	Date
Pap smear	
Mammogram	
Breast Exam	
Bone Density Exam	
Colonoscopy	
Flexible Sigmoidoscopy	
Hemoccult Cards	
Age menstrual cycle began:	Frequency of menstrual cycle:
Length of periods:	Date of last menstrual period: