PRIMARY CARE PARTNERS
Your Partner in Health

Primary Care Partners New Patient Intake

Thank you for choosing our office for your primary care needs. Please complete this form and bring it to your appointment.

Name: ______________________________ Date of birth: ______________ Age: ________

Reason for visit: ________________________ How did you hear about us? ____________________

Date of last physical/well child exam: ____________________ PAP Smear (females): ________________

Name of Gynecologist (females): ______________________ Date of last Mammogram: ______________

Name of Gastroenterologist (GI Dr): ______________________ Date of last colonoscopy: ____________

Date of last Flu Vaccine: ______________________ Date of last Pneumonia Vaccine: ______________

Dates of HPV Vaccines: ________________ ___________________ ___________________

Diabetic patients:

Date of last dilated eye exam: _____________________ HgbA1C: ________ result: ______________

Name of eye care professional: __________________________________

Name of Endocrinologist: __________________________________

Patients 18 and over:

In the last year have you:

Fallen causing injury? Yes No Been to the emergency room? Yes No # of times: ________

Admitted to the hospital? Yes No # of times: ________

Over the **<u>last 2 weeks</u>** how often have you been bothered by the following problems?

	Not at all	Several Days	More than ½ the days	Everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Do you currently smoke tobacco products? Yes No Packs per day: ________

Are you interested in quitting? Yes No

Have you previously smoked tobacco products? Yes No Quit Date: ________ Packs per day: ________

Do you drink alcohol? Yes No If so, how often? Daily # times per week______ rarely

Type consumed: Beer Whiskey other__________