WAYNE STATE UNIVERSITY
PHYSICIAN GROUP

New Patient Intake

LMP____/___/_____

Weight_____

Height_____

B/P _____/_____

Pulse_____

Resp._____

Today's Date:___/___/_____

Patient Name_____ Birth Date____/___/_____

Address_____City_____ Zip _____

E-Mail Address_____ Home Ph #_____ Cell #_____

Sex: M F Marital Status: Single Married Divorced Widowed

Spouse's Name_____ Spouse Birth Date____/___/_____

Referred by/ How did you hear about us? _____

Legal Guardian Name, if appl. _____Ph #_____

Allergies: ☐ None

☐ Latex ☐ Iodine ☐ IV Dye ☐ Penicillin ☐ Sulfa ☐ _____ ☐ _____

Medication List: *(example: Lipitor 20mg 1 x day)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy Name: _____

Address_____ City_____

Phone # _____

We offer e-Prescribe for our patient's convenience

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Reason for Visit: 1) _____ 2) _____

HEALTH MAINTENANCE:

Test/Exam	Last
Physical	_____
GYN/PAP	_____
Mamogm	_____
Colonoscpy	_____
Lipids	_____
Flu Shot	_____
Prostatev	_____
Tetanus	_____
(*Example 08/2001*)	

FAMILY HISTORY:

	Mother	**F**ather	**S**ister	**B**rother
Alive & Well	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
_____	☐	☐	☐	☐

PAST MEDICAL HISTORY:

Check all that apply:

- ☐ **NO** Past Medical History
- ☐ Angina (chest pain)
- ☐ Arthritis: Rheumatoid/Osteo
- ☐ Asthma
- ☐ BPH (enlarged prostate)
- ☐ Blood Clots
- ☐ Cancer_____
- ☐ Cerebrovascular/ Stroke
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's/ Irritable Bowel
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD (acid reflux)
- ☐ Hypertension :↑ BP
- ☐ M.I./heart attack
- ☐ Osteoporosis
- ☐ Peptic/ Ulcer
- ☐ Renal/ Kidney
- ☐ Seizures
- ☐ Thyroid disease
- ☐ _____other
- ☐ _____other

PAST SURGICAL HISTORY:

Check all that apply:

- ☐ **NO** Past Surgical History
- ☐ Appendectomy (appendix removed)
- ☐ Back Surgery_____
- ☐ C-Section
- ☐ **Cardiac:** ☐ Angioplasty ☐ Angio w/stent ☐ Pacemaker ☐ CABG
- ☐ Carpal Tunnel
- ☐ Cataract
- ☐ Hernia Repair
- ☐ Joint Replacement_____
- ☐ Pacemaker
- ☐ Tonsillectomy
- ☐ Tubal Ligation/Hysterectomy
- ☐ Other:_____
- ☐ Other:_____

Patient Name: ____

SOCIAL HISTORY:

Language: Spoken ☐ English ☐ _________________

Education: Completed ☐ High School/ GED ☐ College ☐ PhD ☐ ____________

Employment: ☐ NO ☐ YES Employer:________________________________ ☐ Full Time ☐ Part Time

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Children: ☐ No ☐ Yes #_____children

With whom do you live? ______________________________ House ☐ Apt ☐ Other ☐_________________

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Tobacco Use: Yes ☐ No ☐ Previous ☐ / Year Quit? ________

Passive Smoke Exposure (does anyone smoke in your home?) Yes ☐ No ☐

Alcohol Use: No ☐ Yes ☐ ____Daily ____ Weekly ____Monthly _____Yearly

Have you ever sought treatment for alcohol abuse? No ☐ Yes ☐ ______ Age

Family History of Alcoholism No ☐ Yes ☐ ____ (relationship)

Caffeine Use: None ☐ Soda POP ☐ ____x day Coffee ☐ ____x day Tea ☐ ____x day

Do you exercise? No ☐ Yes ☐ Type ______________________ #_________days/week

Religion: None ☐ Christian ☐ Jewish ☐ Muslim ☐ Buddhist ☐ Hindu ☐ Other ____________ ☐

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Street Drug Use: No ☐ Formerly ☐ Yes, currently ☐ Type_____________ How Often? ________

Have you ever sought treatment for drug abuse? No ☐ Yes ☐ ______Age when treated

Family History of Drug Use/ Abuse No ☐ Yes ☐ _______________________(relationship)

Psychiatric Hx: Have you ever had a psychiatric problem? No ☐ Yes ☐ ______________________(problem)

Family history of psychiatric problems: No ☐ Yes ☐ ______________(problem)________________(relationship)

Abuse/Violence: History of Child Abuse No ☐ Yes ☐ History of Domestic Violence No ☐ Yes ☐

Sexually Active? No ☐ Yes ☐ Heterosexual ☐ Homosexual ☐ #____Current Partners # _____lifetime

Condom Use: No ☐ Yes ☐ Birth Control Used:____________ History STDs: No ☐ Yes ☐ __________Type