

WAYNE STATE
UNIVERSITY
PHYSICIAN GROUP

LMP ___/___/___

Weight _____

Height _____

B/P ___/___

Pulse _____

Resp. _____

New Patient Intake

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

Reason for Visit: 1) _____ 2) _____

HEALTH MAINTENANCE:

Test/Exam Last

- Physical _____
- GYN/PAP _____
- Mamogm _____
- Colonoscopy _____
- Lipids _____
- Flu Shot _____
- Prostatev _____
- Tetanus _____

(Example 08/2001)

FAMILY HISTORY:

	Mother	Father	Sister	Brother
Alive & Well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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