

Adult New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Legal Sex*: _____ Home Phone: _____ Mobile Phone: _____
Preferred Phone: Home or Mobile (circle one) Email: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____ Patient Marital Status: _____
Occupation: _____ Employer: _____
Primary Care Provider (PCP): _____ PCP Phone: _____
Referring Provider: _____ Referring Phone: _____
Preferred Pharmacy: _____ Pharm Phone: _____
Preferred Pharmacy Address: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- Decline Response
 Hispanic or Latino
 Not Hispanic or Latino

Race:

- Decline Response
 American-Indian or Alaska Native
 Asian

- Black or African American
 Native Hawaiian or Pacific Islander
 White Other

Preferred Language: _____

- Decline Response

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

- Received N/A (only if you received the notice from ColumbiaDoctors previously)

Information Disclosure and Consent

ColumbiaDoctors will provide you with the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

Please refer to our website: columbiadoctors.org, for a list of insurances accepted by your provider.

*Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Name:

DOB:

Reason for today's visit:

Please be aware that the name and sex you have listed on your insurance

General Medical Questionnaire

Have you EVER had any of the following?

- Asthma/Breathing Problems..... Y N Heart Disease/Disorder Y N
- Arthritis..... Y N Lung Disorder..... Y N
- Bleeding/Clotting Disorder..... Y N Liver Disease Y N
- Blood Pressure Disorder..... Y N Neurological Disorder/Chronic Headaches.. Y N
- Blood Transfusion Y N Psychiatric Disorder/Illness..... Y N
- Bowel/Stomach Problems..... Y N Pulmonary Embolism/DVT Y N
- Cancer..... Y N Stroke..... Y N
- Cholesterol Disorder Y N Seizure or Epilepsy Y N
- Diabetes..... Y N Thyroid Disorder Y N
- Eye Disorder (i.e. Glaucoma, cataract)..... Y N Urinary/Kidney Disorder..... Y N
- If Relevant:** Gynecological Issues..... Y N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		<input type="checkbox"/> Y <input type="checkbox"/> N	
Father		<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	

Do you currently smoke? Y N If no, previously? Y N Years smoked _____ Packs/day _____

Do you use other tobacco products? Y N Consume alcohol? Y N If yes, drinks/week: _____

If Relevant: Any past pregnancies? Y N How many? ____ How many deliveries? ____

Name:

DOB:

Do you have any allergies to medications or other substances (pets, food, etc.)? Y N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

Constitutional

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N Weight Gain (___ Lbs) | <input type="checkbox"/> Y <input type="checkbox"/> N Sleep Disturbances |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chills | <input type="checkbox"/> Y <input type="checkbox"/> N Feeling Poorly | <input type="checkbox"/> Y <input type="checkbox"/> N Weight Loss (___ Lbs) | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Sweats | <input type="checkbox"/> Y <input type="checkbox"/> N Unexp. Weight Change | |

Head, Eyes, Ears, Nose, and Throat

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Vision Problem | <input type="checkbox"/> Y <input type="checkbox"/> N Red Eyes | <input type="checkbox"/> Y <input type="checkbox"/> N Congestion | <input type="checkbox"/> Y <input type="checkbox"/> N Hoarseness |
| <input type="checkbox"/> Y <input type="checkbox"/> N Decreased Hearing | <input type="checkbox"/> Y <input type="checkbox"/> N Eye Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Snoring | <input type="checkbox"/> Y <input type="checkbox"/> N Ringing in Ears |
| <input type="checkbox"/> Y <input type="checkbox"/> N Double Vision | <input type="checkbox"/> Y <input type="checkbox"/> N Runny Nose | <input type="checkbox"/> Y <input type="checkbox"/> N Dry Mouth | <input type="checkbox"/> Y <input type="checkbox"/> N Vertigo |
| <input type="checkbox"/> Y <input type="checkbox"/> N Light Sensitivity | <input type="checkbox"/> Y <input type="checkbox"/> N Neck Stiffness | <input type="checkbox"/> Y <input type="checkbox"/> N Flu-Like Symptoms | <input type="checkbox"/> Y <input type="checkbox"/> N Earache |
| <input type="checkbox"/> Y <input type="checkbox"/> N Itchy Eyes | <input type="checkbox"/> Y <input type="checkbox"/> N Nosebleed | <input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat | <input type="checkbox"/> Y <input type="checkbox"/> N Other: |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Extremities | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular Heart Rhythm |
| <input type="checkbox"/> Y <input type="checkbox"/> N Palpitations | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Hands or Feet | <input type="checkbox"/> Y <input type="checkbox"/> N Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Leg Swelling | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Pain w/ Walking | |

Respiratory

- | | | | |
|---|---|--|--------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Wheezing | <input type="checkbox"/> Y <input type="checkbox"/> N Coughing Up Blood | <input type="checkbox"/> |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Coughing Up Sputum | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rapid Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Chest Congestion | <input type="checkbox"/> Other: | |

Gastrointestinal

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea | <input type="checkbox"/> Y <input type="checkbox"/> N Change in Bowels | <input type="checkbox"/> Y <input type="checkbox"/> N Painful Swallowing |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood in Stool | <input type="checkbox"/> Y <input type="checkbox"/> N Black/Tarry Stools | <input type="checkbox"/> Y <input type="checkbox"/> N Vomiting Blood | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Vomiting | <input type="checkbox"/> Y <input type="checkbox"/> N Decreased Appetite | <input type="checkbox"/> Y <input type="checkbox"/> N Bowel Incontinence | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nausea | <input type="checkbox"/> Y <input type="checkbox"/> N Yellow Skin | <input type="checkbox"/> Y <input type="checkbox"/> N Rectal Pain | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Constipation | <input type="checkbox"/> Y <input type="checkbox"/> N Trouble Swallowing | <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn | |

Name: _____

DOB: _____

Neurological

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Headache | <input type="checkbox"/> Y <input type="checkbox"/> N Unsteady | <input type="checkbox"/> Y <input type="checkbox"/> N Numbness | <input type="checkbox"/> Y <input type="checkbox"/> N Tremor |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N Disorientation | <input type="checkbox"/> Y <input type="checkbox"/> N Tingling | <input type="checkbox"/> Y <input type="checkbox"/> N Memory Lapses/Loss |
| <input type="checkbox"/> Y <input type="checkbox"/> N Decreased Strength | <input type="checkbox"/> Y <input type="checkbox"/> N Confusion | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Poor Coordination | <input type="checkbox"/> Y <input type="checkbox"/> N Burning Sensation | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting (Syncope) | |

Musculoskeletal

- | | | | |
|--|--|---|---------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Joint Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Limb Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Pain | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Neck Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Joint Swelling | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Weakness | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Cramps | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Swelling | |

Genitourinary

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Urination | <input type="checkbox"/> Y <input type="checkbox"/> N Pelvic Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Painful Intercourse | <input type="checkbox"/> Y <input type="checkbox"/> N Heavy Period Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Incontinence | <input type="checkbox"/> Y <input type="checkbox"/> N Nocturia | <input type="checkbox"/> Y <input type="checkbox"/> N Discharge- Vaginal | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Urinary Urgency | <input type="checkbox"/> Y <input type="checkbox"/> N Itching- Genital | <input type="checkbox"/> Y <input type="checkbox"/> N Vaginal Bleeding | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Painful Urination | <input type="checkbox"/> Y <input type="checkbox"/> N Change in Libido | <input type="checkbox"/> Y <input type="checkbox"/> N Irreg. Monthly Cycles | |

Integumentary

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Rash | <input type="checkbox"/> Y <input type="checkbox"/> N Skin Wound | <input type="checkbox"/> Y <input type="checkbox"/> N Unusual Growth | <input type="checkbox"/> Y <input type="checkbox"/> N Skin Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dry Skin | <input type="checkbox"/> Y <input type="checkbox"/> N Change in A Mole | <input type="checkbox"/> Y <input type="checkbox"/> N Itching | <input type="checkbox"/> Other: |

Psychiatric

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Depression | <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety | <input type="checkbox"/> Other: |
|--|---|---------------------------------|

Hematologic/Lymphatic

- | | | | |
|---|---|---|---------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Easy Bruising | <input type="checkbox"/> Y <input type="checkbox"/> N Easy Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen Lymph Nodes | <input type="checkbox"/> Other: |
|---|---|---|---------------------------------|

Endocrine

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Thirst | <input type="checkbox"/> Y <input type="checkbox"/> N Heat Intolerance | <input type="checkbox"/> Y <input type="checkbox"/> N Changes- Skin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cold Intolerance | <input type="checkbox"/> Y <input type="checkbox"/> N Changes- Hair | <input type="checkbox"/> Other: |

OFFICE USE ONLY: Provider Signature: _____ Date: _____