MEDICAL ARTS PHYSICIANS
INITIAL PATIENT VISIT

DATE: _____

NAME: _____

D.O.B.: _____ S.S.# _____ SEX: ___M ___F

ALLERGIES: _____ B.M.I. _____

REFERRING PHYSICIAN: _____ OR REFERRED BY: _____

PRIMARY CARE DOCTOR: _____ LAST VISIT: _____

WOULD YOU LIKE TO MAKE US AWARE OF FAMILY OR FRIENDS IN OUR PRACTICES? IF SO, PLEASE LIST:

_____

DO YOU HAVE FAMILY EMPLOYED AT HMC? ___ YES ___ NO WHO? _____

MEDICAL INSURANCE: __ COMMERCIAL __ CAT __ BC/BS __MEDICARE __ MEDICAID __ NONE __ OTHER

PLEASE PROVIDE RECEPTIONIST WITH A COPY OF CARD UPON INITIAL REGISTRATION

PRESCRIPTION COVERAGE FOR MEDICATIONS? ___ YES ___ NO

WHICH PHARMACY DO YOU LIKE TO USE FOR YOUR PRESCRIPTIONS? _____

CITY: _____ **TELEPHONE:** _____

PAST SURGICAL HISTORY

DATE	PROCEDURE

ENDOSCOPY PROCEDURES

DATE	DIAGNOSIS/TEST/DOCTOR

PAST MEDICAL HISTORY

_____

RISK FACTORS

___ HIGH BLOOD PRESSURE
___ DIABETES MELLITUS
___ SMOKING
___ PACKS PER DAY
___ SMOKELESS TOBACCO
___ HIGH CHOLESTEROL
___ HEART DISEASE OR STROKE
___ OBESITY (BMI ≥ 30)
___ ASTHMA
___ ALCOHOLISM
OTHER

FAMILY HISTORY

MI _____
DIABETES _____
STROKE _____
ANEURYSM _____
DEPRESSION _____
CANCER:
COLON _____
BREAST _____
LUNG _____
GYNE _____
OTHER _____

_____

_____