Lenzmeier Family Medicine

New Patient Intake Form

Name:____ **DOB:** ___________________

MEDICATIONS:

Please list **MEDICATION ALLERGIES**: ____

Please List **CURRENT PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS** and dose:
Example: Metformin 1000mg 1 pill twice daily, Baby aspirin 1 pill daily, Multivitamin 1 pill daily

1.____ 2.____

3.____ 4.____

5.____ 6.____

7.____ 8.____

9.____ 10.____

11.____ 12.____

****

Past Surgeries and Procedures: (please check)

ANGIOPLASTY
APPENDECTOMY
BREAST BIOPSY
BREAST AUGMENTATION
CARDIAC CATHETERIZATION
CESAREAN SECTION
COLECTOMY (PARTIAL OR COMPLETE COLON REMOVAL)
COSMETIC SURGERY
D & C (DILATION & CURRETAGE)
EGD (UPPER GI SCOPE)
FOOT SURGERY
HAND SURGERY
HEART STENTS
HYSTERECTOMY
KIDNEY STONE REMOVAL
LASIK EYE SURGERY
LUMPECTOMY
NASAL SURGERY
PROSTATE SURGERY
SINUS SURGERY
SPINAL SURGERY (LUMBAR, CERVICAL, THORACIC)
TUBAL LIGATION (TUBES TIED)
WRIST SURGERY
WISDOM TEETH EXTRACTION
OTHER SURGERIES NOT LISTED ABOVE: ____

ANKLE SURGERY
BLOOD TRANSFUSION
BREAST REDUCTION
BRONCHOSCOPY
CATARACT SURGERY
CHOLECYSTECTOMY (GALLBLADDER REMOVAL)
COLONOSCOPY
CYSTOSCOPY
EAR SUGERY
EYE SURGERY
GASTRIC BYPASS
HEART BYPASS (CABG)
HERNIA REPAIR
JOINT REPLACEMENT (KNEE, HIP, SHOULDER)
KNEE SURGERY (SCOPE, OPEN)
LAPRASCOPY (EXPLORATORY)
MASTECTOMY
ORAL SURGERY
SHOULDER SURGERY
SPLENECTOMY
TONSILLECTOMY/ADENOIDECTOMY
THYROIDECTOMY
VASECTOMY

Past Medical Diagnoses: (please check)

ACNE
ALLERGIC RHINITIS (HAYFEVER)
ANXIETY
ASTHMA
BACK PAIN
BIPOLAR DISORDER
ATTENTION DEFICIT DISORDER
ANEMIA
ARTHRITIS (OSTEOARTHRITIS, RHEUMATOID)
ATRIAL FIBRILLATION
BARRETTS ESOPHAGUS
BPH (BENIGN PROSTATE ENLARGEMENT)

CANCER (BLADDER, BRAIN, BREAST, CERVICAL, COLON, LUNG, KIDNEY, LEUKEMIA, LYMPHOMA, MULTIPLE MYELOMA, OVARIAN, PANCREATIC PROSTATE, SKIN (BASAL CELL, MELANOMA, SQUAMOUS CELL), UTERINE
OTHER____

CHF (CONGESTIVE HEART FAILURE)
CARDIAC/HEART MURMUR
CHRONIC KIDNEY DISEASE (STAGE II/III/IV/V)
CHRONIC SINUSITIS
CAD (CORANARY HEART DISEASE)
CROHN'S DISEASE
DEPRESSION
DIVERTICULOSIS OF COLON
ECZEMA
ED (ERECTILE DYSFUNCTION)
FIBROMYALGIA
GLAUCOMA
HEMORRHOIDS
HERPES (GENITAL, ORAL)
HISTORY OF DRUG ABUSE
HYPERTENSION (HIGH BLOOD PRESSURE)
HYPOGONADISM (LOW TESTOSTERONE)
IBS (IRRITABLE BOWEL SYNDROME)
KIDNEY STONE
LUNG NODULE (SPOT ON THE LUNG)
MACULAR DEGENERATION
MIGRAINE HEADACHES
MULTIPLE SCLEROSIS
OBSTRUCTIVE SLEEP APNEA
OSTEOPOROSIS
PERIPHERAL VASCULAR DISEASE
PSORIASIS
RESTLESS LEG SYNDROME
TIA (MINI STROKE)
ULCERATIVE COLITIS
VALLEY FEVER (COCCIDIOMYCOSIS)
VITAMIN D DEFICIENCY
OTHER PROBLEMS NOT LISTED ABOVE
CARPAL TUNNEL SYNDROME
COLON POLYPS
CHRONIC PAIN SYNDROME
COPD (EMPHESEMA)
COLON POLYPS
DEMENTIA
DVT (DEEP BLOOD CLOT)
DIABETES (ADULT, JUVENILE ONSET)
ENDOMETRIOSIS
FIBROIDS, UTERINE
GERD (HEART BURN)
GOUT
HEPATITIS (A, B, C, UNKNOWN)
HIATAL HERNIA
HYPERLIPEDMIA (HIGH CHOLESTEROL)
HYPERTHYROIDISM (HIGH THYROID)
HYPOTHYROIDISM (LOW THYROID)
INSOMNIA
LIVER TESTS ABNORMAL
LUPUS (SYSTEMIC)
MENOPAUSAL SYMPTOMS
MITRAL VALVE PROLAPSE
OBESITY
OSTEOPENIA
PEPTIC ULCER DISEASE (STOMACH ULCER)
POLYCYSTIC OVARIAN SYNDROME
PE (PULMONARY EMBOLISM)
STROKE
TUBERCULOSIS
URINARY URGENCY (OVERACTIVE BLADDER)
VITAMIN B12 DEFICIENCY

____
____
____
____

SOCIAL HISTORY: (please circle)

Marital Status: Married Single Divorced Widowed Other

How Many Children? _________

Who do you live with? Spouse Children Significant Other Room-mate Parents Siblings
Others____

Do you have any pets? Dog Cat Birds Fish Other____

Occupation: Employed PT Employed FT Retired Stay at home parent Unemployed Disabled Student

What is your Occupation? ____

Nutrition: Poor Diet Average Diet Good Diet Excellent Diet Vegetarian Diet

Exercise: None Occasional Walking Regular Walking Occasional Running Regular Running Occasional Cardio Regular Cardio Occasional Resistance Training Regular Resistance Training Yoga Active lifestyle but no regular exercise.

Sexual Activity: Not Sexually Active Monogamous Multiple Partners

Contraception: None Oral Contraceptive(the Pill) Condoms IUD Diaphragm Depo-Provera Nuva- Ring Patch Natural Family Planning Vasectomy Menopause.

Sexual Orientation: Straight Gay Bi-Sexual

Smoking: Never a Smoker Former Smoker Current Smoker
If a Current Smoker: Smoking Amount: 1/4 PPD 1/2 PPD 1 PPD 2 PPD Occasional
Are you exposed to Second Hand Smoke? NO Yes (smokes inside smokes outside)

Alcohol: None Rare Current Use Former Alcohol Dependence
If Current Use: Average Alcohol Amount: Less than 1 drink/day 1-2 drinks/day 2-3 drinks/day 3-4 drinks/day more than 4 drinks/day.

Illicit Drug: None Former Cocaine Marijuana Methamphetamine Heroin Prescription
Other__________________________

Seatbelt Use: Yes No Occasional

Family History: (please check)

Mother: If Deceased age _______, Alive. Medical Problems: Cancer, Diabetes, Heart Problems,
Unknown Other:____

Father: If Deceased age _______, Alive. Medical Problems: Cancer, Diabetes, Heart Problems,
Unknown Other:____

Siblings: Number____ Medical Problems: Cancer Diabetes Heart Problems
Other: ____

Initial Health Maintenance History:

When was your last Wellness Visit or Complete Physical? ____

Have you had a Colonoscopy? Never or Date last completed _____________________________________

Have you had a Tetanus Vaccine? Never or last completed ______________________________________

Have you had a Pneumovax (Pneumonia Vaccine)? Never or last completed_______________________

Have you had a Shingles Vaccine? Never or last completed______________________________________

Have you had a Flu Shot this Fall/Winter Season? No or last completed___________________________

If Female:

Have you had a PAP smear? Never or Date last completed________________________________

Have you had a Mammogram? Never or Date last completed______________________________

Have you had a Bone Density Test? Never or Date last completed__________________________

When was the date of your LMP (Last Menstrual Period)? ________________________________

Pregnancy_________ Live Births___________ Living Children______________

If Child:

Please bring your Vaccine Records to your first visit.

****

Demographics:

Preferred Nickname: ____

Email Address:____

Preference for Reminders (please check one): Letters Phone Secure Email

Sex (please check one): Male Female

Race (please check one): White Asian Black/African American American Indian/Alaskan Native Native Pacific Islander Decline

Ethnicity (please check one): Hispanic/Latino None Hispanic/Latino Decline

Preferred Language (please check one): English Spanish Other _________________________

Would you like secure internet access to your medical records at home? (please check one): Yes No Maybe

How did you find Lenzmeier Family Medicine (who referred you)? ____