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.**

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
Arthritis ☐ Y ☐ N
Bleeding/Clotting Disorder ☐ Y ☐ N
Blood Pressure Disorder ☐ Y ☐ N
Blood Transfusion ☐ Y ☐ N
Bowel/Stomach Problems ☐ Y ☐ N
Cancer ☐ Y ☐ N
Cholesterol Disorder ☐ Y ☐ N
Diabetes ☐ Y ☐ N
Eye Disorder (i.e. Glaucoma, cataract) ☐ Y ☐ N
If Relevant: Gynecological Issues ☐ Y ☐ N

Heart Disease/Disorder ☐ Y ☐ N
Lung Disorder ☐ Y ☐ N
Liver Disease ☐ Y ☐ N
Neurological Disorder/Chronic Headaches ☐ Y ☐ N
Psychiatric Disorder/Illness ☐ Y ☐ N
Pulmonary Embolism/DVT ☐ Y ☐ N
Stroke ☐ Y ☐ N
Seizure or Epilepsy ☐ Y ☐ N
Thyroid Disorder ☐ Y ☐ N
Urinary/Kidney Disorder ☐ 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		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ 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? ____

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

□Y□N Fever
□Y□N Chills
□Y□N Fatigue
□Y□N Feeling Poorly
□Y□N Sweats
□Y□N Weight Gain (___ Lbs)
□Y□N Weight Loss (___ Lbs)
□Y□N Unexp. Weight Change
□Y□N Sleep Disturbances
□ Other:

Head, Eyes, Ears, Nose, and Throat

□Y□N Vision Problem
□Y□N Decreased Hearing
□Y□N Double Vision
□Y□N Light Sensitivity
□Y□N Itchy Eyes
□Y□N Red Eyes
□Y□N Eye Pain
□Y□N Runny Nose
□Y□N Neck Stiffness
□Y□N Nosebleed
□Y□N Congestion
□Y□N Snoring
□Y□N Dry Mouth
□Y□N Flu-Like Symptoms
□Y□N Sore Throat
□Y□N Hoarseness
□Y□N Ringing in Ears
□Y□N Vertigo
□Y□N Earache
□Y□N Other:

Cardiovascular

□Y□N Chest Pain
□Y□N Palpitations
□Y□N Leg Swelling
□Y□N Cold Extremities
□Y□N Cold Hands or Feet
□Y□N Leg Pain w/ Walking
□Y□N Irregular Heart Rhythm
□Y□N Other:

Respiratory

□Y□N Shortness of Breath
□Y□N Cough
□Y□N Rapid Breathing
□Y□N Wheezing
□Y□N Shortness of Breath
□Y□N Chest Congestion
□Y□N Coughing Up Blood
□Y□N Coughing Up Sputum
□ Other:
□

Gastrointestinal

□Y□N Abdominal Pain
□Y□N Blood in Stool
□Y□N Vomiting
□Y□N Nausea
□Y□N Constipation
□Y□N Diarrhea
□Y□N Black/Tarry Stools
□Y□N Decreased Appetite
□Y□N Yellow Skin
□Y□N Trouble Swallowing
□Y□N Change in Bowels
□Y□N Vomiting Blood
□Y□N Bowel Incontinence
□Y□N Rectal Pain
□Y□N Heartburn
□Y□N Painful Swallowing
□ Other:

Neurological

☐Y☐N Headache	☐Y☐N Unsteady	☐Y☐N Numbness	☐Y☐N Tremor
☐Y☐N Dizziness	☐Y☐N Disorientation	☐Y☐N Tingling	☐Y☐N Memory Lapses/Loss
☐Y☐N Decreased Strength	☐Y☐N Confusion	☐Y☐N Seizures	☐ Other:
☐Y☐N Poor Coordination	☐Y☐N Burning Sensation	☐Y☐N Fainting (Syncope)	

Musculoskeletal

☐Y☐N Joint Pain	☐Y☐N Limb Pain	☐Y☐N Muscle Pain	☐ Other:
☐Y☐N Neck Pain	☐Y☐N Joint Swelling	☐Y☐N Muscle Weakness	
☐Y☐N Back Pain	☐Y☐N Muscle Cramps	☐Y☐N Leg Swelling	

Genitourinary

☐Y☐N Frequent Urination	☐Y☐N Pelvic Pain	☐Y☐N Painful Intercourse	☐Y☐N Heavy Period Bleeding
☐Y☐N Incontinence	☐Y☐N Nocturia	☐Y☐N Discharge- Vaginal	☐ Other:
☐Y☐N Urinary Urgency	☐Y☐N Itching- Genital	☐Y☐N Vaginal Bleeding	
☐Y☐N Painful Urination	☐Y☐N Change in Libido	☐Y☐N Irreg. Monthly Cycles	

Integumentary

☐Y☐N Rash	☐Y☐N Skin Wound	☐Y☐N Unusual Growth	☐Y☐N Skin Cancer
☐Y☐N Dry Skin	☐Y☐N Change in A Mole	☐Y☐N Itching	☐ Other:

Psychiatric

☐Y☐N Depression	☐Y☐N Anxiety	☐Other:

Hematologic/Lymphatic

☐Y☐N Easy Bruising	☐Y☐N Easy Bleeding	☐Y☐N Swollen Lymph Nodes	☐ Other:

Endocrine

☐Y☐N Excessive Thirst	☐Y☐N Heat Intolerance	☐Y☐N Changes- Skin
☐Y☐N Cold Intolerance	☐Y☐N Changes- Hair	☐ Other:

OFFICE USE ONLY: Provider Signature: ______________________________ Date: ______________