EDGERTON HOSPITAL MILTON CLINIC

New Patient Forms

Patient's Name: _____ Today's Date: ____/____/____

Date of Birth: ___/___/___ SS#: ____/____/____ Sex: MALE / FEMALE

Email: _____

Phone: ____-____-____ (Mobile) ____-____-____ (Work) ____-____-____ (Home)
Preferred (✔): ___ Mobile ___ Work ___ Home

Ethnicity (✔): _____ African American _____ American Indian/Eskimo _____ Caucasian
___ Hispanic or Latino Origin ___ Not Hispanic or Latino Origin ____ Declined

Race (✔): ____ American Indian/Alaskan Native ____ Asian _____African American
_____ Multi-racial ____ Native Hawaiian or Pacific Islander _____Caucasian
_____Declined

Marital Status (✔): ___ Single ___ Married ___ Widowed ___ Divorced ___ Separated

Maiden Name (if applicable): _____

Employer: _____

Occupation: _____ Part time/Full time

Emergency Contact: Name:_____

Address: _____

Phone: _____ Relationship: _____

(Please note any additional Emergency Contacts you would like added in the space below)

Please bring a copy of your most recent insurance card

Health Concerns to Share with Provider:

Allergies:

Allergy	Reaction	Date Noted (if known)

Medications (include prescription and non-prescription):

Name of Medication and Strength	Dose	Frequency	Need Refills? (✔)

What Pharmacy do you use?: _____

Health Maintenance:

Topic	Date	Location of Service	Comments
Mammogram			
Pap Smear			
Bone Density			
Colonoscopy			
Eye Exam			
Fasting Lab Draw			

Immunization	Most Recent Date	Location of Service	Comments
Tetanus			
Pneumonia			
Influenza			

Health Habits:

Tobacco Use: (✔one)
___ Current every Day Smoker
___ Current some day smoker
___ Former smoker
___ Never smoker
___ Passive smoke exposure-never smoker

Which type?: Cigarettes / Pipe / Cigars / Vape

Start Date: _____ Number of years: _____
Packs per day: _____ Quit Date: _____

Drug Use?: YES* / NO ***If yes, what type:**
_____

Alcohol Use:
How often do you have a drink containing alcohol? (✔one)
___ Never
___ Less than Monthly
___ Monthly
___ Weekly
___ 2-3 Times a Week
___ 4-6 Times a Week
___ Daily

How many drinks containing alcohol do you have on a typical day when you are drinking? (✔one)
___ 1 Drink
___ 2 Drinks
___ 3 Drinks
___ 4 Drinks
___ 5-6 Drinks
___ 7-9 Drinks
___ 10 or more Drinks

How often do you have 4 or more drinks on one occasion? (✔one)
___ Never
___ Less than Monthly
___ Monthly
___ Weekly
___ 2-3 Times a Week
___ 4-6 Times a Week
___ Daily

Fall Risk:
Are you afraid of falling? YES / NO
Have you fallen in the last year? YES* / NO

***If yes:**
Date of fall: _____
How many times: _____
Were you injured: YES* / NO

***If yes:** Describe injury:
_____
_____

Depression Screening:
Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things? (✔one)
___ Not at all
___ Several days
___ More than half the days
___ Nearly everyday

Feeling down, depressed, or hopeless? (✔one)
___ Not at all
___ Several days
___ More than half the days
___ Nearly everyday

Advance Directive (Living will or Durable Power of Attorney for Health Care):

Do you have an Advance Directive? YES / NO

Do we have a copy? YES / NO*

***If not, please bring a copy to this appointment.**

Abuse Screening:

Do you feel safe at home? YES / NO

Have you ever been hit, hurt or felt threatened by someone? YES / NO

Personal Medical History:

	(✔)		(✔)		(✔)
Neurological					
CVD (Stroke)		Headaches		Peripheral Neuropathy	
concussion		Multiple Sclerosis		Seizure disorder	
Cardiac					
Arrhythmia		congestive Heart Failure		Hyperlipidemia	
Atrial Fibrillation		Cardiomyopathy		Peripheral Vascular Disease	
Coronary Artery Disease		Hypertension		Valvular Heart disease	
Ear/Nose/Mouth/Throat					
Allergic Rhinitis		Chronic Sinusisits		Macular Degeneration	
Cataracts		Glaucoma		Retinopathy	
Chronic Otitis		Hearing Loss			
Respiratory					
Asthma		Emphysema		Pulmonary Fibrosis	
COPD		Pneumonia		Sleep Apnea	
Chronic Bronchitis		Pulmonary Hypertension			
Gastrointestinal					
Chronic Constipation		Diverticular Disease		Irritable Bowel Disease	
Chronic Diarrhea		GERD		Inflammatory Bowel Disease	
Cirrhosis		GI bleed		Pancreatitis	
Colon Polyps		Hemorrhoids		Peptic ulcer Disease	
Chrohn's Disease					
Genitourinary					
BPH		ESRD (End Stage Renal Disease)		Kidney Stone	
Chronic Renal (kidney) Disease		Incontinence		Recurrent UTIs	
Reproductive					
Abnormal PAP Smears		Fibroids		Polycystic Ovarian Syndrome	
Dysmenorrhea		Menstrual Disorder		Pelvic Inflammatory Disease	
Endometriosis		Ovarian Cyst		Sexually Transmitted Disease	
Musculoskeletal					
Arthritis		Fibromyalgia		Osteopenia	
Chronic Back Pain		Gout		Osteoporosis	
Chronic Pain Syndrome		Osteoarthritis		Rheumatoid Arthritis	
Endocrine					
Gestational Diabetes		Hyperthyroidism		Type 1 DM	
Hypothyroidism		Obesity		Type 2 DM	
Hematology					
Anemia		Deep Vein Thrombosis		PE (Pulmonary Embolism)	
Bleeding Disorder		Hemophilia		Thrombocytopenia	
Skin					
Acne		Eczema		Rosacea	
Chronic Dermatitis		Psoriasis		Warts	

Other medical history not listed:

_____

_____

Personal Surgical History:

Surgery	Date	Name of Facility	Surgeon's Name

Family History: Adopted?: Yes / No

(✔) Family members have the following conditions	Mother	Father	Sister	Brother	Mat Gmother	Mat Gfather	Pat Gmother	Pat Gfather	Other
Alcohol/Drug Abuse									
Allegies									
Anesthesia Problems									
Arthritis									
Asthma									
Attention Defiicit Disorder									
Autoimmune Disease									
Brith/Congenital Defect									
Blood Disease (anemia or bleeding disorder)									
Cancer									
Clotting Disorder									
Depression									
Diabetes Mellitus									
Early Death									
Elevated Lead Level									
Endocrine Disease									
Genetic Disorder									
GI (Stomach/Intestinal) Disease									
Hearing Loss									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Learning Disabilities									
Mental Illness									
Migraines									
Multiple Sclerosis									
Neurologic Disease									
Obesity									
Polycystic Ovarian Syndrome									
Rheumatologic Disease									
Seizures / Epilepsy									
Stroke									
Thyroid Disease									
Vision Loss									

Others not listed:

_____

_____

Signature of patient or parent (if minor): _____Date: _____

Thank you for your time in providing this information!

Please use the area below for any additional information for which you did not have space above