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NEW PATIENT INTAKE FORM

Patient Name:_____ Date of Birth:_____ Today's date:_____

Welcome to Ridge Medical Associates, LLC. Please take a few minutes to fill out the information below. By filling the form completely and accurately, you will assist greatly in providing high quality care to you. If you have any questions, please ask one our staff members.

1. What is the reason for your visit today? _____

2. Do you suffer from any medical conditions or disease? Please check all that apply:

□ High blood pressure □ Diabetes (high blood sugar) □ Hyperlipidemia (cholesterol disorders)

□ COPD (emphysema) □ Asthma □ Coronary artery disease (blockage in heart)

□ Heart failure □ artificial heart valve □ atrial fibrillation (irregular heartbeat)

□ Irritable bowel syndrome □ Colon polyps □ Cancer, type_____

□ Anemia (low blood) □ arthritis □ Auto-immune disorder_____

□ Other conditions not mentioned above: _____

_____

3. Have you had any surgeries? If yes, please tell us what kind and when they were done:
_____

_____

4. Are you currently experiencing or have you recently experienced any of the following symptoms? Please check all that apply:
□ Weight Loss □ Fever □ Chills □ Shortness Of Breath □ Chest Pain □ Cough □ Nausea □ Vomiting □ Diarrhea

□ Blood In Stools □ Abdominal Pain □ □ Urinary Frequency □ Burning With Urination □ Blood In Urine

□ Joint Pains □ Falls □ Loss Of Balance □ Dizziness □ Tingling/Numbness □ Blurred Vision □ Anxiety □

Depression □ Suicidal Thoughts □ Hearing Voices □ Loss Of Memory □ Confusion

5. Do you smoke? □ Yes _____ packs a day □ Never smoked □ Past smoker (quit _____ years ago)

6. Do you drink alcohol? □ Yes, I drink □ regularly □ occasionally □ heavily
□ No † Past use

7. Do you use recreational drugs? □ Yes. If yes, what kind? _____
□ No □ Past use: _____

8. Have you had preventative health screening done? □ yes □ No. If yes, please explain below:
Females: □ Last mammogram:____ □ Last pap smear:_____ □ Last colonoscopy:____ Cholesterol:____
Males: □ Last colonoscopy:_____ Cholesterol:_____

9. Are there any diseases or conditions that run in your family? If yes, please explain:_____ __

_____

6. Do you suffer from any allergies? If yes, please explain:_____

_____

7. When is the last time you had: a. Flu vaccine:_____ b. Pneumonia vaccine:_____ c. Tetanus vaccine

8. Please list all your medications, including herbal and over the counter medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

9. Which pharmacy do you use? This one will be put in computer and used for future reference:
Local pharmacy name_____ City:_____ Mail order pharmacy: _____