PRIMARY CARE PARTNERS
Your Partner in Health

Primary Care Partners New Patient Intake

Thank you for choosing our office for your primary care needs. Please complete this form and bring it to your appointment.

Name: _____ Date of birth: _____ Age: _____

Reason for visit: _____ How did you hear about us? _____

Date of last physical/well child exam: _____ PAP Smear (females):_____

Name of Gynecologist (females): _____Date of last Mammogram:_____

Name of Gastroenterologist (GI Dr): _____Date of last colonoscopy: _____

Date of last Flu Vaccine: _____ Date of last Pneumonia Vaccine: _____

Dates of HPV Vaccines: _____ _____ _____

Diabetic patients:

Date of last dilated eye exam: _____ HgbA1C: _____ result: _____

Name of eye care professional: _____

Name of Endocrinologist: _____

Patients 18 and over:

In the last year have you:

Fallen causing injury Y/N Been to the emergency room Y / N # of times: _____

Admitted to the hospital Y /N # of times: _____

Over the **last 2 weeks** how often have you been bothered by the following problems?	Not at all	Several Days	More than ½ the days	Everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Do you currently smoke tobacco products? Y / N Packs per day: _____ Are you interested in quitting? Y/ N

Have you previously smoked tobacco products? Y / N Quit Date: _____ Packs per day: _____

Do you drink alcohol? Y / N If so, how often? Daily _____ times per week rarely

Type consumed: beer whiskey other_____