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New Patient Medical History Form

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**.

Patient Name:		Date of Visit:
Date of Birth:	Age:	***Preferred Phone:***
Preferred email:		Social Security Number:
Address:		***Emergency Contact (Name and Number):***
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner		Spouse/Significant Other:
Employer:		Occupation:
INSURANCE CARRIER:		**INSURANCE ID #:**
Does your insurance plan require referrals for specialty visits? ❑ Yes ❑ No		If YES, do you have a referral for today's visit? ❑ Yes ❑ No

Physician and Pharmacy Information	
Primary Care Provider (Name/Phone/Fax Number):	**Preferred Pharmacy** (Name/Phone/Fax Number/Address):
Referring Physician (Name/Phone/Fax Number): ❑ Same as PCP	**Other Physician to send records to** (Name/Phone/Fax Number):
Specialty:	Specialty:
Other Physician to send records to (Name/Phone/Fax Number):	**Other Physician to send records to** (Name/Phone/Fax Number):
Specialty:	Specialty:

Reason/s For Visit:

Medical History

Please include all medical problems even if not relevant to this visit. If no medical problems, write none.

Current or Past Medical Problems	Dates	Reasons

Hospitalizations/Surgeries	Dates	Reason

Allergies (Medication, Food, Cosmetics, Etc.)	Cause/Nature of Reaction

Medications/Supplements	Dosage/Frequency	Condition/Reason

Family and Social History			
Family History: **Mother**	Family History: **Father**	Family History: **Siblings**	Family History: **Children**
❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:

Do you drink **alcohol**?	Do you **smoke**?	Do you use recreational **drugs**?
❑ Never ❑ Yes. I drink ❑ wine ❑ beer ❑ liquor ❑ I have _____ drink(s) per week ❑ I used to drink but quit in _____ (year)	❑ I never smoked ❑ Yes. I smoke ❑ cigarettes ❑ cigars ❑ pipes. ❑ I currently smoke and I don't want to quit ❑ I currently smoke but I'm ready to quit. ❑ I smoke _____ pack(s) per day for _____ years ❑ I used to smoke but quit in _____(year) ❑ I use chewing or smokeless tobacco	❑ Never ❑ No, but I have used _____ ❑ Yes, I use _____

Do you eat or drink foods containing **caffeine?**	Have you taken any **aspirin, Advil, Nuprin** (NSAIDs) in the last 7 days?
❑ Yes ❑ No	❑ Yes (if so, what medication? _____) ❑ No

Do you **exercise**?	**If yes, how often and what type?**
❑ Yes ❑ No	

Date of most recent colonoscopy/endoscopy:	Date of most recent flu shot:	Date of most recent pneumonia shot (age 65+):

How did you hear about us?

❑ Physician ❑ Family/Friend ❑ Internet ❑ Health Plan ❑ Advertisement ❑ Referral Service ❑ Weill Cornell Connect ❑ Int'l Office

Communication Consent

I hereby authorize the physician and/or the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

❑ Home Telephone/Answering Machine ❑ Work Telephone ❑ Cell Phone/Voicemail ❑ Email ❑ Regular Mail

List of Authorized people that can received your medical information *(other than medical professionals listed on page 1)*

Name: _____ Phone Number: _____ Relation: _____

Name: _____ Phone Number: _____ Relation: _____

Name: _____ Phone Number: _____ Relation: _____

The information is accurate and complete to the best of my knowledge.
I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.

Patient Signature:	Physician Signature:

Name of person completing form (if not patient): Signature: Today's Date:	Today's Date:

Review of Systems

Please check 'YES' or 'NO' for EACH item

Constitutional
❑ Normal
Y N
❑ ❑ Fever
❑ ❑ Chills
❑ ❑ Night sweats
❑ ❑ Weight loss/gain
❑ ❑ Sleep disturbance
❑ ❑ Fatigue
❑ ❑ Poor appetite

Eyes
❑ Normal
Y N
❑ ❑ Contact lenses or glasses
Type: _____
❑ ❑ Blurry vision
❑ ❑ Glaucoma
❑ ❑ Cataracts
❑ ❑ Retinal detachment
❑ ❑ Macular degeneration
❑ ❑ Blindness
❑ ❑ Redness
❑ ❑ Tearing
❑ ❑ Dryness
❑ ❑ Double Vision
❑ ❑ Discharge
❑ ❑ Pain

Ear
❑ Normal
Y N
❑ ❑ Hearing loss
❑ ❑ Hearing aids
❑ ❑ Wax
❑ ❑ Ear pain
❑ ❑ Ringing/noise/tinnitus
❑ ❑ Previous ear surgery
❑ ❑ Loud noise exposure

Respiratory
❑ Normal
Y N
❑ ❑ Asthma
❑ ❑ Emphysema/COPD
❑ ❑ Bronchitis
❑ ❑ Pneumonia
❑ ❑ Aspiration
❑ ❑ Tracheotomy
❑ ❑ Tuberculosis
❑ ❑ Coughing blood
❑ ❑ Shortness of breath
❑ ❑ Wheezing
❑ ❑ Cough over 3 months
❑ ❑ Pulmonary embolus

Nose
❑ Normal
Y N
❑ ❑ Congestion
❑ ❑ Mucus
❑ ❑ Post nasal drip
❑ ❑ Sinus infection
❑ ❑ Sinus headaches
❑ ❑ Nose Bleeds

Allergy
❑ Normal
Y N
❑ ❑ Sneezing
❑ ❑ Runny Nose
❑ ❑ Itchy ears, eyes, or nose
❑ ❑ Transplant
❑ ❑ Hives

Throat
❑ Normal
Y N
❑ ❑ Voice problems
❑ ❑ Swallowing problems
❑ ❑ Throat Pain
❑ ❑ Phlegm
❑ ❑ Feeling of something stuck
❑ ❑ Tonsil infections/problems

Sleep
❑ Normal
Y N
❑ ❑ Snoring
❑ ❑ Sleep Apnea
❑ ❑ CPAP/BiPAP/AutoPAP
❑ ❑ Insomnia
❑ ❑ Choking/Gasping
❑ ❑ Restless leg
❑ ❑ Daytime sleepiness

Gastrointestinal
❑ Normal
Y N
❑ ❑ Diarrhea
❑ ❑ Constipation
❑ ❑ Blood in stool
❑ ❑ Vomiting/nausea
❑ ❑ Ascites
❑ ❑ Heartburn/acid reflux
❑ ❑ Abdominal pain
❑ ❑ Ulcers
❑ ❑ Diverticulitis
❑ ❑ IBD
❑ ❑ Hepatitis
❑ ❑ Gallstones
❑ ❑ Pancreatitis
❑ ❑ Jaundice
❑ ❑ Cirrhosis

Endocrine
❑ Normal
Y N
❑ ❑ Diabetes
❑ ❑ Thyroid problems
❑ ❑ Autoimmune disease
Type: _____
❑ ❑ Immune deficiency
❑ ❑ Excessive thirst
❑ ❑ Swollen lymph nodes
❑ ❑ Cold/heat intolerance
❑ ❑ Gout

Neurologic/Neuromuscular
❑ Normal
Y N
❑ ❑ Headaches/migraines
❑ ❑ Encephalopathy
❑ ❑ Seizures
❑ ❑ Tremors
❑ ❑ Numbness
❑ ❑ Stroke
❑ ❑ Imbalance/vertigo
❑ ❑ Lightheaded/fainting
❑ ❑ Memory loss
❑ ❑ Unexplained weakness

Hematologic
❑ Normal
Y N
❑ ❑ Bruise easily
❑ ❑ Anemia
❑ ❑ Leukemia/Lymphoma
❑ ❑ Blood clots
❑ ❑ Bleeding disorders
❑ ❑ History of radiation

Oral/Dental
❑ Normal
Y N
❑ ❑ Dentures/implants
❑ ❑ Temporomandibular joint
❑ ❑ Teeth clenching/grinding
❑ ❑ Tongue problems
❑ ❑ Mouth lesions

Genitourinary
❑ Normal
Y N
❑ ❑ Frequent urination
❑ ❑ Prostate problems
❑ ❑ Urine/bladder infections
❑ ❑ Yeast infections
❑ ❑ Incontinence
❑ ❑ Kidney problems/stones
❑ ❑ Dialysis
❑ ❑ Transplant

Skin
❑ Normal
Y N
❑ ❑ Past skin cancer
Type: _____
❑ ❑ Skin biopsy
Site: _____
❑ ❑ Eczema
❑ ❑ Rash or skin sensitivity
❑ ❑ Abnormal skin moles
❑ ❑ History of skin disease
❑ ❑ Hair loss/growth
❑ ❑ Itching
❑ ❑ Keloid scars

Musculoskeletal
❑ Normal
Y N
❑ ❑ Neck pain
❑ ❑ Arthritis
❑ ❑ Back pain/spinal problems
❑ ❑ Fractures
❑ ❑ Muscle pain
❑ ❑ Swelling
❑ ❑ Joint/bone pain

Cardiovascular
❑ Normal
Y N
❑ ❑ Heart attack
❑ ❑ High blood pressure
❑ ❑ High cholesterol
❑ ❑ Stents
❑ ❑ Coronary artery disease
❑ ❑ Irregular heart beat
❑ ❑ Chest pains
❑ ❑ Leg swelling
❑ ❑ Pacemaker/defibrillator

Psychiatric
❑ Normal
Y N
❑ ❑ Anxiety
❑ ❑ Depression
❑ ❑ Bi-polar
❑ ❑ Psychosis

Men's/Women's Health
❑ Normal
Y N
❑ ❑ Sexual problems
❑ ❑ Genital lesions
❑ ❑ Enlarged prostate (BPH)
❑ ❑ Abnormal discharge
❑ ❑ Cancer
Type: _____

Any other comments/problems/concerns:

Financial Policy

Thank you for choosing OceanMed Clinic for your health-care needs. The following is our Payment Policy which we require you to read and sign.

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accepts the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your ID, medical insurance and/or Medicare card and a copy of your credit card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at time of service.

We understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please call our 310-444-2911 to discuss a satifactory arrangement.

Participating Plans

You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company. Patients without insurance cards or proper referrals (if needed) will be asked for full payment at time of service. All co-pays, deductibles and non-covered services will be collected at time of service.

Non-Participating Plans

If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier or a claim can be mailed to you.
Payment in full is due at the time of service for all non-medically necessary services and/or cosmetic services.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for your payment regardless of any insurance company's arbitrary determination of usal and customary rates.

Payment

For your convenience, the following payment methods are accepted: Cash, personal check, Visa, MasterCard, Amex, Discover.

_____
Credit Card Number

_____ _____
Expiration Date CVC

I have read the policy, I understand and agree to it.

_____ _____
Print Name & Sign Date