Adult New Patient Intake Form

Patient Information

Last Name: ____________ First Name: ____________ DOB: ____________
Preferred Name: ____________ Preferred Pronoun: ________ Sex (as listed on insurance card): _____
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.

ColumbiaDoctors

Reason for today's visit:

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	

Social History

Do you currently smoke? □ Yes □ No If no, previously? □ Yes □ No Years smoked ______ Packs/ day _____
Do you use other tobacco products? □ Yes □ No Consume alcohol? □ Y □ N If yes, drinks/ week: ______

Reproductive/ Sexual Health

Are you sexually active? □ Yes □ No

Do you consider yourself to be? □ Heterosexual or straight □ Gay or lesbian □ Bisexual □ Not listed, please state: ________________

What sex were you assigned at birth? □ Male □ Female

Current gender identity? □ Male □ Female □ Transgender Male/Trans man □ Transgender Female/ Trans woman □ Genderqueer/non-binary □ Other, please state:___________________

In the past year, have you had sex with? □ Men only □Women only □ Both men and women □ Not listed, please state: ___________ □ I have not had sex

Have you had any sexually transmitted diseases? □ Yes □ No

Would you like to be tested for HIV? □ Yes □ No

If relevant: Date of your last menstruation or age of menopause _______

Last Pap Smear ________ Last mammography _________

If relevant: Any past pregnancies? □ Yes □No How many? ___ How many deliveries? ____

Do you have any discharge from or lumps in your breast or chest? □ Yes □ No

If relevant: Do you have sores or lumps on your penis or testicles? □ Yes □ No

Functional Assessment

Do you use any equipment (such as a walker or wheelchair) to assist in your daily life? □ Yes □No If yes, what? ____________

Do you have difficulty performing daily tasks such as bathing, dressing or cooking? □ Yes □No

Have you fallen in the past 6 months? □ Yes □No

Do you have difficulty with balance or walking? □ Yes □No

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

Fever ☐Y☐N	Sweats ☐Y☐N	Unexplained Weight Change ☐Y☐N
Chills ☐Y☐N	Weight Gain (___ Lbs) ☐Y☐N	Trouble Sleeping ☐Y☐N
Fatigue ☐Y☐N	Weight Loss (___ Lbs) ☐Y☐N	☐ Other:
Feeling Poorly ☐Y☐N		

Head, Eyes, Ears, Nose, and Throat

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

Cardiovascular

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

Respiratory

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

Gastrointestinal

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

Neurological

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 ☐Y☐N	☐ Other:
Poor Coordination ☐Y☐N	Burning Sensation ☐Y☐N	Fainting (Syncope) ☐Y☐N	

Musculoskeletal

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

Genitourinary

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

Integumentary

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 ☐Y☐N	☐ Other:

Psychiatric

Depression ☐Y☐N	Anxiety ☐Y☐N	☐Other:

Hematologic/Lymphatic

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

Endocrine

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