Dr. Sumanth Padman New Patient Intake Form

ARBOR MEDICAL

This form asks for a comprehensive medical history. Please complete this form prior to your first visit.

To The Best of Your Ability - Please Complete The Following:

Date: _____ **Date of Birth:** _____
Name: _____ **Sex:** _____
Address: _____
_____

Phone Number **(Home):** _____ **(Cell):** _____
(Work): _____

(Email): _____

Referring Physician (if applicable): _____
Phone: _____

Primary Physician (if applicable): _____
Phone: _____

Pharmacy: **Name:** _____
Address _____
Phone: _____

Main Reason for Today's Visit: _____

ALLERGIES: List the drug(s) to which you have an allergy and describe the particular symptoms.

1) _____
2) _____
3) _____
4) _____
5) _____

CURRENT MEDICATIONS: (more room on last page if necessary)
(Remember to include "over the counter" drugs such as aspirin, Tylenol, Motrin, eye drops, laxatives & vitamins supplements. Also include creams, ointments and birth control preparations.)

Name	**Dosage**	**Frequency**

PAST MEDICAL HISTORY (Check all items that apply to you)

_____ **Anemia**
_____ **Arthritis**
_____ **Asthma**
_____ **Cancer (type)**
_____ **Bowel Problems**
_____ **COPD/Emphysema**
_____ **Diabetes**
circle (type 1 type 2)
_____ **Epilepsy**
_____ **Hearing Loss**
_____ **Heart disease**
_____ **Hepatitis: circle (A B C)**
_____ **HIV / AIDS**
_____ **High Blood Pressure**
_____ **Thyroid: circle (High / Low)**
_____ **Kidney Disease / Stones**
_____ **Mental Illness / Depression**
_____ **Heart Burn / Acid Reflux**
_____ **Sexually Transmitted Disease**
_____ **Sickle Cell Anemia/Trait**
_____ **Skin disease (eczema, psoriasis)**
_____ **Stroke**

Other: _____

_____

PAST SURGICAL HISTORY (Check all items that apply to you)

_____ **Angioplasty**
_____ **Appendectomy**
_____ **Breast Procedure R / L**
_____ **Gallbladder / gallstone removal**
_____ **Hernia Repair**
_____ **Hysterectomy**
_____ **Knee (R / L) Replacement**
_____ **Fracture Repair**

Other: _____

_____

FAMILY MEDICAL HISTORY

This includes illnesses in your parents, your siblings and your children.

Relationship	**Illness**

Has anyone in your family been diagnosed with colon cancer?

_____ yes
_____ no

If you answered yes to the above question, who? _____

Has anyone in your family been diagnosed with breast cancer?

_____ yes
_____ no

If you answered yes to the above question, who? _____

Has anyone in your family been diagnosed with ovarian cancer?

_____ yes
_____ no

If you answered yes to the above question, who? _____

SOCIAL HISTORY

Are you a current smoker?

_____ yes
_____ no

If you answered yes to the above question, how many packs per day do you smoke? _____
What year did you start smoking? _____
Would you be interested in a smoking cessation program?

_____ yes
_____ no

If you are not currently smoking, have you smoked in the past?

_____ yes
_____ no

If you answered yes to the above question, what year did you start smoking? _____
What year did you stop smoking? _____

Are you currently working? (check one)

_____ yes
_____ no

If you answered yes to the above question, what is your occupation?_____
If yes, who is your current employer? _____

Are you on disability? (check one)

_____ yes
_____ no

If yes, how long have you been disabled? _____
What was your cause of disability? _____

Do you exercise?

_____ yes
_____ no

If you answered yes to the above question, how often? _____

Have you been exposed to hazardous materials?

_____ yes
_____ no

Are you on any special diet (i.e.. Vegetarian, Keto, etc.)

_____ yes
_____ no

Are any of you medical complaints part of an active legal case?

_____ yes
_____ no

ARBOR MEDICAL

Personal Health Assessment

To The Best of Your Ability - Please Complete The Following:

PERSONAL HEALTH RECOMMENDATIONS / SCREENINGS

Do you have any advance care planning (Living Will)?

_____ yes
_____ no
If you answered yes to the above question, when did you complete it? _____

When was your last complete eye exam?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Have you had osteoporosis screening (DEXA) / treatment?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Have you had a colon cancer screening (ex. colonoscopy)?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Have you had any lung cancer screening exams?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Are you a current smoker? (if you answered this before please disregard)

_____ yes
_____ no
If you answered yes to the above question, how many packs per day do you smoke? _____
What year did you start smoking? _____
Would you be interested in a smoking cessation program?
_____ yes
_____ no

If you are not currently smoking, have you smoked in the past? (if you answered this before please disregard)

_____ yes
_____ no
If you answered yes to the above question, what year did you start smoking? _____
What year did you stop smoking? _____

Have you been tested for Hepatitis C?

_____ yes
_____ no

(Date of birth 1945-1965) History of blood transfusion?

_____ yes
_____ no

Personal Health Assessment (continued)

(Date of birth 1945-1965) History of intravenous drug use?

_____ yes
_____ no

For Women, have you had any of the following?

Mammogram

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Pap smear

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

For Men, have you had any of the following?

PSA level check (Prostate)

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Ultrasound for Abdominal Aortic Aneurism (AAA) - if you were a smoker?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Do you have a history of falls?

_____ yes
_____ no

Do you have a history of balance issues?

_____ yes
_____ no

If you have diabetes:

Have you had any testing for A1c?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Have you had any testing for Cholesterol (LDL)?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

Have you had a diabetic foot exam?

_____ yes
_____ no
If you answered yes to the above question, when was it? _____

ARBOR MEDICAL

Immunization Form

To The Best of Your Ability - Please Complete The Following.

If you have had one of the following vaccines, please write when you last received it below.

Date Completed

Pneumonia:

Prevnar 13 (Pneumococcal conjugate) (> age of 18) _____

Pneumovax 23 (Pneumococcal polysaccharide) (> age of 65) _____

Influenza (recommended yearly) _____

Shingles (either one or both of the following):

Zostavax (recommended once after age 65) _____

Shingrex (recommended once after age 50) _____

Tetanus/diphtheria/pertussis (Tdap) (recommended once) _____

Tetanus/diphtheria Booster (recommended every 10 years after Tdap) _____

***Patient has been advised to receive age appropriate vaccinations.**

PHYSICIAN USE ONLY

- ☐ Pneumonia:
  - ☐ Prevnar 13 (Pneumococcal conjugate)
  - ☐ Pneumovax 23 (Pneumococcal polysaccharide)
- ☐ Influenza
- ☐ Shingles:
  - ☐ Zostavax
  - ☐ Shingrex
- ☐ Tetanus/diphtheria/pertussis (Tdap)
- ☐ Tetanus/diphtheria Booster

ARBOR MEDICAL

PHQ-9: Depression Screening Questionnaire

	Not at all	Some Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you are a failure or have let your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed OR the opposite- being so restless that you have been moving around more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

Total Score: _____

CAGE Questionnaire: Alcohol Screening Use Questionnaire

How many times in the past year have you had 5 or more drinks in a day? _____

you answered 1 or more to the previous question, please complete the following (circle YES or NO

Do you get angry when others comment about your drinking?	Y	N
Are you concerned about your drinking?	Y	N
Do you feel guilty about drinking?	Y	N
Have you ever had a drink in the morning to calm your nerves?	Y	N

REVIEW OF SYSTEMS

Please check any of the following problems you are currently experiencing:

Constitutional:

_____ Weight change
_____ Fatigue
_____ Weakness
_____ Fever

Eyes, Nose, Throat:

_____ Sore Throat
_____ Dizziness
_____ Hearing Loss
_____ Ringing in Ears
_____ Nasal Congestion
_____ Glaucoma

Cardiovascular:

_____ Palpitations
_____ Chest Pain
_____ Shortness of Breath
_____ Ankle Swelling

Respiratory:

_____ Cough
_____ Change in Breathing
_____ Wheezing

Gastrointestinal:

_____ Heartburn
_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Abdominal Pain
_____ Constipation
_____ Bowel Incontinence
_____ Bloody Stool

Genitourinary:

_____ Urgency
_____ Blood in Urine
_____ Pain with Urination
_____ Bladder Incontinence

Musculoskeletal:

_____ Joint Pain
_____ Stiffness
_____ Neck or back Pain
_____ Require Walking Assistive Device (cane, walker, etc.)

Skin:

_____ Rash
_____ Lumps
_____ Wounds that Won't Heal
_____ Nail or Hair Changes

Neurological:

_____ Headache
_____ Numbness
_____ Seizures
_____ Weakness
_____ Memory Loss
_____ Black Outs

Psychological:

_____ Nervousness
_____ Depression
_____ Tension
_____ Anxiety

Endocrine:

_____ Sweating
_____ Hunger
_____ Heat / Cold Intolerance
_____ Thirst

Hematologic:

_____ Bruising
_____ Bleeding

Do you have anything additional that you would like your doctor to know or would like to discuss with your doctor that has not already been covered in this form? If yes, please describe below.

Additional Medications:

Name	**Dosage**	**Frequency**

Without your expressed and written consent, all medical information remains confidential.

SIGNATURE OF PATIENT: _____

DATE: _____