CORE PHYSICIANS
an exeter health resource | The Art of Wellness

Requested PCP:

NEW PATIENT INFORMATION

Date: ______________ **How did you hear about us:**

Last Name:		First Name:		MI:	
Previous Last Name:		Preferred Name:			
Address:					
City/State/Zip:					
Home Phone:		Cell Phone:		Work Phone:	
Email:					
Date of Birth:		Birth Sex:		Gender:	
Legal Status:	Self	Legal Guardian	If self, continue to Advance Directives.		
Name:		Contact Info:			
Surrogate	Exp. Date				
Name:		Contact Info:			
Paperwork on file:	Yes	No			
Advance Directives:	Yes	No	If yes, please bring a copy with you to your first appointment.		
Emergency Contact Name:		Home Phone:			
Relationship:		Cell Phone:			

Social History

Tobacco - Smoking Status			**Alcohol**			
Use Tobacco: ☐ Current Former ☐ Never			Drink Alcohol?	☐ Yes	☐ No	☐ Formerly
How many smoked per day?			Frequency:	Daily	Weekly	Monthly
What age did you start smoking?				Occasionally	Rarely	Socially
Passive Smoke Exposure?	Yes	No				
Tobacco Cessation Attempts?	Yes	No				

Caffeine:	Coffee ☐ Soda ☐ Energy Drinks ☐ Tea ☐	Cups Per Day:	

Marital Status | Family | Social Support

Current status:	☐ Married	☐ Single	☐ Divorced	☐ Widowed	☐ Life Partner	☐ Legally Separated
Children:	Number of Sons: Number of Daughters:					

Patient Name:		*Date of Birth:*	

Education | Employment | Occupation | Military Service								
Primary Language Spoken:				Language Spoken at Home:				
Country of Birth:				Hand Dominance:	Right	Left	Ambidextrous	
Education:	Elementary	High School	College	GED	Tech School	Degree Obtained:		
Employer:				Occupation:				
Retire Year:				Military Experience:			Yes	No
Lifestyle	Moderate	Sedentary	Vigorous	Changes in Sleep Patterns?			Yes	No
Health Club Member?	Now	Previously	Never					
Type of Exercise/ Frequency:		| |		Animals in Home?			Yes	No
Home Environment | Safety								

Smoke Detectors:	Yes	No	Pool/Spa:	Yes	No	Home Heating:	Yes	No
Carbon Monoxide:	Yes	No	Firearms:	Yes	No	Use Seat Belt?	Yes	No
Radon in Home:	☐ Yes ☐ No ☐ Treated ☐ Untested					Use Bike Helmet?	Yes	No

Medical & Surgical History

Year:	Description of Disease, Condition or surgery:	Year:	Description of Disease, Condition or surgery:

Patient Name:		*Date of Birth:*	

Family History (Blood Relatives)

☐ Patient Adopted

Family Member Age	Diagnosis - Use list below and write in all that apply:
Mother	
Father	
Sister	
Sister	
Sister	
Brother	
Brother	
Brother	
Other Relative	

Use these terms as applicable:

Alive & Well	Asthma	CVA (Stroke)	Hearing Deficiency	Mental Illness	PVD
Add/ ADHD	Blood Disease	Depression	Hyperlipidemia	Migraines	Renal Disease
Alcoholism	CAD	Developmental Delay	Hypertension	Obesity	Seizure Disorder
Allergies	CAD-Premature	Diabetes	Irritable Bowel (IBS)	Osteoarthritis	Osteoporosis
Alzheimer's Disease	Cancer	Eczema	Learning Disability		Other

Medication(s)

Medication Name	Dose		Medication Name	Dose

Pharmacy Name & Location: ______________________

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Patient Name:		*Date of Birth:*	

Allergies

☐ No Known Allergies

Include food and drug allergies and adverse reactions

Ingredient | Allergen	Brand Name	Reaction

Specialty Physicians

Specialist Seen (i.e., ob-gyn, cardiologist, orthopedist)

Specialty:		Specialist Name:
City, State:		Phone Number:

Specialty:		Specialist Name:
City, State:		Phone Number:

Specialty:		Specialist Name:
City, State:		Phone Number:

Specialty:	Dentist	Specialist Name:
City, State:		Phone Number:

Specialty:	Ophthalmologist *(Eye Doctor)*	Specialist Name:
City, State:		Phone Number:

If you would prefer to fax form please save, print and fax to 603-580-6644.