Hudson Valley Primary Care - Patient Intake Form

Please fill out the following information. We enter this information in our new electronic medical record system. If you are unsure of a question, or do not feel well enough to complete this form you may ask for assistance from the medical assistant when you are called back. Thank you.

Name:_____ D.O.B. _____

Provider you are seeing today: Dr. Foster Dr. Rubinstein Amy Kelly, N.P.

Medications No Yes

If yes, please list medication and dosage: **Ex:** Aspirin 325mg 1 tablet daily

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Allergies No Yes

Please list drug allergy(s) and reaction(s): **Ex:** Penicillin Rash

_____ _____ _____ _____ _____ _____ _____ _____

Chronic Illness No Yes,

If yes, please list any chronic illnesses: Ex: Diabetes, Hypertension, Heart Disease, Asthma

_____ _____ _____ _____ _____

Past Medical History Please check all that apply:

None Allergies (seasonal) Angina Arthritis Asthma Cancer (type: _____)

Chronic Bronchitis/Emphysema Coronary Artery Disease Depression Diabetes

Gallbladder Disease GERD Heart Attack High Cholesterol High Blood Pressure

Migraines Osteoporosis Peptic Ulcer Disease Seizure Disorder Stroke Thyroid Disease

Other (please specify):_____

Past Surgical History Please check all that apply:

None Angioplasty Appendectomy Back Surgery Breast Augmentation Breast Reduction

C-Section Carpal Tunnel Release Cataracts Colostomy Dilation & Curettage

Gastric Bypass Gall Bladder Removal Hernia Repair Hip Replacement Hysterectomy

Knee Scope Knee Replacement LASIK Mastectomy Pacemaker Thyroid Removal

Tonsil Removal Tubal Ligation

Other (please specify):_____

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Family History Please check all that apply: ☐ None ☐ **Adopted**

	Family Member:		Family Member:		Family Member:
☐ ADD/ADHD	_____	☐ Depression	_____	☐ Mental Illness	_____
☐ Alcoholism	_____	☐ Diabetes	_____	☐ Migraines	_____
☐ Alzheimer's	_____	☐ Eczema	_____	☐ Obesity	_____
☐ Arthritis	_____	☐ High Cholesterol	_____	☐ Osteoporosis	_____
☐ Asthma	_____	☐ High Blood Pressure	_____	☐ Kidney Disease	_____
☐ Coronary Artery Disease	_____	☐ Irritable Bowel Disease	_____	☐ Seizure Disorder	_____
☐ Cancer (type:_____)	_____	☐ Learning Disability	_____	☐ Stroke	_____

Social History

Are there any occupational hazards at your place of employment such as: asbestos, chemicals, excessive noise, potentially toxic fumes? ☐ No ☐ Yes, please list: _____

Do you use tobacco products? ☐ No ☐ Yes: Type:_____ Amt Per Day:_____ Number of Years:_____

Do you drink alcohol? ☐ No ☐ Yes: Type:_____How often?(ex: weekly)_____
Amount: (ex: 2 beers)_____

Do you drink ☐ coffee? ☐ tea? ☐ soda? ☐ No ☐ Yes: Amount per Day: (ex. 2 cups)_____

Do you use any recreational/illegal drugs? ☐ No ☐ Yes: Type: _____

Immunizations (approximate date is okay)

	Date: (mm/dd/yy)	
Flu shot	_____	☐ None
Pneumonia shot	_____	☐ None
Tetanus shot	_____	☐ None

Health Maintenance Date of Exam: (mm/dd/yy)

If you are over the age of 18:
Date of last Physical Exam _____ ☐ None

If you are Female:
When was your last mammogram? _____ ☐ None

When was your last pap smear? _____ ☐ None

If you are over the age of 35:
Date of last cholesterol lab test? _____ ☐ None

If you are Male over the age of 50:
When was the date of your last prostate exam? _____ ☐ None

If you are over the age of 50:
When was your last colonoscopy? _____ ☐ None

If you are over the age of 65:
When was your last Osteoporosis screening? _____ ☐ None

Medical Record Use Only: Abstracted by _____