David W. Newell, MD

P: 206-661-6100 F: 866-282-9644

PATIENT DEMOGRAPHICS

Name:____ DOB:____/____/_____ Age:____ Sex: _______
Last First Middle Initial

Address:____
Street Address City State Zip

Cell Phone:________________ Home Phone:____________________ Email:__________________________________

How did you hear about us? ☐ Google Search ☐ Facebook ☐ Instagram ☐ YouTube

☐ Other advertisement:____

☐ Referral from (patient or doctor):____

Who is your primary care doctor?____

INSURANCE INFORMATION

Primary Insurance: __________________ **Subscriber ID**: ____________________ **Group #:** ___________________

Primary Card Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other:______________________________

_________________________________/____________________________________
Name of Policy Holder Date of Birth of Policy Holder

Copay: $______

Secondary Insurance: __________________ **Subscriber ID**: ____________________ **Group #:** ________________

Primary Card Holder: ☐ Self or ☐ Spouse ☐ Parent ☐ Other:______________________________

_________________________________/____________________________________
Name of Policy Holder Date of Birth of Policy Holder

Copay: $______

Does this visit pertain to a worker's compensation injury or an MVA claim? ☐ YES ☐ NO, If Yes,
Date of Injury:__________ Claim #:______________ Adjuster Name:____________Phone Number:___________

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ADDITIONAL INFORMATION

Occupation:____

Marital Status: ☐ Married ☐ Single ☐ Other:______________

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Other:___________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic / Latino ☐ Other:______________________________________

Language Spoken: ☐ English ☐ Spanish ☐ Other:___________________________________

Emergency Contact:___________ Phone Number: ______________ Relationship: ____________________

REASON FOR VISIT

Please Tell Us the Reason for your Visit: ____

____

PHARMACY INFORMATION

Preferred Pharmacy: ____
Pharmacy Address: ____ Phone: ___________________

MEDICATION ALLERGIES

❑ No Known Drug Allergies

❑ No Known Allergies to latex, contrast, or adhesives.

❑ Yes, I have known Drug Allergies (Please list name and symptoms)

1. ______________________________________ 4. ______________________________________
2. ______________________________________ 5. ______________________________________
3. ______________________________________ 6. ______________________________________

❑ Yes, I have other Allergies to things like latex, contrast, or adhesives (Please list name and symptoms)

1. ______________________________________ 3. ______________________________________
2. ______________________________________ 4. ______________________________________

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CURRENT MEDICATIONS

LIST ALL CURRENT MEDICATIONS YOU ARE TAKING

NAME:	**DOSE**	**FREQUENCY**	**REASON PRESCRIBED**
Example: Aspirin	*81mg*	*one tab a day*	*stroke prevention*
1. ______________	____________	_____________	___________________________
2. ______________	____________	_____________	___________________________
3. ______________	____________	_____________	___________________________
4. ______________	____________	_____________	___________________________
5. ______________	____________	_____________	___________________________
6. ______________	____________	_____________	___________________________
7. ______________	____________	_____________	___________________________
8. ______________	____________	_____________	___________________________
9. ______________	____________	_____________	___________________________
10. ______________	____________	_____________	___________________________
11. ______________	____________	_____________	___________________________
12. ______________	____________	_____________	___________________________
13. ______________	____________	_____________	___________________________
14. ______________	____________	_____________	___________________________
15. ______________	____________	_____________	___________________________

CURRENT SYMPTOMS

Are you currently experiencing any of the following symptoms?

General	Fatigue	Fever/Chills	Weight Loss	Weight Gain
Neurologic	Seizures	Dizziness	Headaches	Loss of Taste/Smell
Musculoskeletal	Joint Pain	Back Pain	Neck Pain	Stiffness
Skin	Rash	Itchiness	Lesions	Redness
Pulmonary	Shortness of breath	Wheezing	Cough	
Cardiac	Chest Pain	Swelling	Irregular heartbeat	
Gastrointestinal	Diarrhea	Nausea / Vomiting	Abdominal Pain	
Genitourinary	Incontinence (urine)	Incontinence (stool)	Painful Urination	
HEENT	Sore Throat	Vision Changes	Difficulty Swallowing	Difficulty Hearing
Psychiatric	Depression	Anxiety	Hallucinations	Mood changes

Other symptoms not listed above: ____

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PAST MEDICAL AND FAMILY HISTORY

Have any of your family members ever been diagnosed with any of the following medical conditions?

Condition	Family Members affected:
Heart Disease	
Heart Attack	
High Blood Pressure	
Stroke	
Blood Clots	
Anemia	
Diabetes	
Epilepsy or history of seizures	
Cancer	
Aneurysm	
Osteoporosis	
Other	

Which of the following conditions have you been treated for in the past or are you currently being treated for?

- ❑ Heart disease
- ❑ Heart Attack
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ High cholesterol
- ❑ Anemia or other bleeding problem
- ❑ Diabetes
- ❑ Arthritis
- ❑ Thyroid problem
- ❑ COPD
- ❑ Asthma
- ❑ Prostate problems: ______________
- ❑ Kidney problems: ________________
- ❑ Liver problems: __________________
- ❑ Cancer: __________________________
- ❑ Hearing loss
- ❑ Vision problems: ________________
- ❑ Seizures
- ❑ Stroke/TIA
- ❑ Headaches / migraines
- ❑ Aneurysm
- ❑ Depression
- ❑ Anxiety
- ❑ Other: _________________________________

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PRIOR SURGERIES / HOSPITALIZATIONS

Please list any surgeries you have had in your lifetime:

1. ____
2. ____
3. ____
4. ____
5. ____

SOCIAL HISTORY

☐ **Right Handed** ☐ **Left Handed** ☐ **Ambidextrous**

Height:______________ **Weight:**______________

What is your sexual orientation?

☐ Heterosexual/Straight ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Other:_________________

What is your gender identity?

☐ Male ☐ Female ☐ Other (please specify): ______________________________

Do you drink alcohol? If so, how would you describe your consumption frequency?

☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Never

Smoking History:

Have you ever smoked? ☐ Yes ☐ No If yes, how long? ________ How many packs/day? _________

Have you quit smoking? ☐ Yes ☐ No If yes, when? ______________________

Street Drug Use (marijuana, cocaine, etc.): ____________________________