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:________________________________

Who referred you to our office? ____

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 workers compensation injury or an MVA claim? ☐YES ☐NO, If Yes,
Date of Injury:_________ Claim #:_____________ Adjuster Name:___________ Phone Number:__________

For office use only:

Dx: **CPT:**

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ADDITIONAL INFORMATION

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: ________________________

Occupation:____

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 Other Allergies (latex, contrast, 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

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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:**_______________

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.): _______________________________

OTHER HEALTH RELATED ISSUES

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