WESTON MEDICAL
HEALTH & WELLNESS

New Patient Internal Medicine & Immigration

1) Personal Details

Family Name (Last Name):	Given Name (First Name):	Middle Name:

Street Number and Name:		□ Apt □ Ste □ Flr	Number:	

City or Town:		State:		Zip Code:	

Email:		Phone Number:	

Gender: □ M □ F	Date of Birth:		City/Town/Village of Birth:	

Country of Birth:		Alien Registration Number(A-Number) (if Any): A-									

Form of Government issued Identification used:	□ Passport	□ Drivers License	□ Other	

Government Issued Identification Number:	
USCIS Online Account Number (if Any) :	

Can you read and understand English? □ Yes □ No	If no, will you bring your interpreter? □ Yes □ No

How did you hear about us?	

2) In Case of Emergency:

Name:		Relationship:		Phone:	
Patient's Spouse:				Phone:	
Family Physician:				Phone:	

3) Financial Policy:

Thank you for selecting Weston Medical Health & Wellness for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept All Major Credit Cards and HSA.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all Collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements**.**

Patient's Signature:		Date:	

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What brings you in today?

What do you prefer to be called (nickname)?	

Please list all of your medical conditions.	
1.	2.
3.	4.
5.	6.
7.	8.

What surgical or medical procedures have you had in the past?	
1.	2.
3.	4.
5.	6.

Please tell us about medical conditions in your family including cancer, diabetes, heart disease, etc., and at what age they developed the disease:			
Mother:		Age:	
Father:		Age:	
Siblings:		Age:	
Others:		Age:	

What medications, herbs, and vitamins/ supplements are you currently taking? Remember to include over-the-counter medicines. Please include the doses and how often you take each one.	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Allergies? Yes No
If "yes", reactions?

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Social History:				
Relationship status:	☐ Married/Partner	☐ Single	☐ Divorced	
Preferred sexual partner:	☐ Men	☐ Women	☐ Never sexually active	
Have you ever been pregnant:	☐ Yes	☐ No	How many times?	
Who lives with you at home?				
Do you feel safe at home and in your current relationship?	☐ Yes	☐ No		
What is your occupation?				
What (if any) physical activity/exercise do you engage in and how often?				
How would you describe your dietary intake?				
How much alcohol do you drink?		per day		per week
If yes, how many times in the past month have you had more than 4 alcoholic drinks in one day?				
Do you smoke?	☐ Now	☐ Past	☐ Never	
If so, how many per day and for how long?				
Have you ever had a blood transfusion?	☐ Yes	☐ No		
How often have you noticed the following emotions over the last two weeks: (check the answer that best describes how you feel)				
Little interest in doing things	☐ None	☐ Several days	☐ More than half the days	☐ Nearly every day
Feeling down or depressed	☐ None	☐ Several days	☐ More than half the days	☐ Nearly every day

Review of Systems: Please check if you are currently having any of the following symptoms.		
Constitutional	**Respiratory**	**Skin**
☐ Fever	☐ Cough	☐ Rash
☐ Night sweats	☐ Trouble breathing	☐ Nail changes

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☐ Weight loss	☐ Frequent Illness	☐ Mole Changes
☐ Fatigue		
☐ Excessive sleepiness/ Insomnia		
Eyes	**Gastrointestinal**	**Endocrinologic**
☐ Blurred vision	☐ Nausea/vomiting	☐ Excessive thirst
☐ Double vision	☐ Diarrhea	☐ Hot or cold always
☐ Eye pain	☐ Constipation	☐ Excessive urination
☐ Eye dryness	☐ Abdominal pain	
	☐ Heartburn	**Hematologic**
		☐ Abnormal bleeding/bruising
		☐ Lumps or swelling
Ear/nose/throat	**Genitourinary**	**Psychiatric**
☐ Hearing loss	☐ Leaking urine	☐ Anxiety
☐ Ringing in ears	☐ Trouble urinating	☐ Sad or depressed
☐ Hoarseness	☐ Blood in urine	☐ Trouble sleeping
☐ Trouble swallowing	☐ Heavy vaginal bleeding	☐ Memory problems
☐ Sneezing frequently		☐ Overwhelming
☐ Runny/Stuffy nose		☐ Panic attacks
☐ Snoring	**Musculoskeletal**	
☐ Choking/gasping during sleep	☐ Muscle pain or joint pain	**Neurologic**
	☐ Muscle twitching/cramping	☐ Numbness/tingling
Cardiovascular	☐ Joint pain/stiffness	☐ Tremors
☐ Chest pain	☐ Joint swelling	☐ Headaches
☐ Palpitations	☐ Trouble walking	☐ Dizziness
	☐ Falls/fear of falling	☐ Memory loss
	☐ Back pain	

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Health Maintenance/Prevention					
Please specify if and when you received the following services.					
All patients:					
☐ Influenza (flu) vaccine	Date:		☐ HIV test	Date:	
☐ Tetanus vaccine	Date:		☐ Last dental exam	Date:	
☐ Pertussis vaccine	Date:		☐ Last eye exam	Date:	
☐ Hepatitis A vaccine	Date:				
☐ Hepatitis B vaccine	Date:				
☐ Varicella vaccine	Date:				
Over 50:					
☐ Pneumonia vaccine	Date:		☐ Blood in stool cards	Date:	
☐ Zostavax vaccine	Date:		☐ Colonoscopy	Date:	
☐ Pertussis vaccine	Date:				
☐ Bone density scan	Date:				
Women only: **All:**					
☐ Pap smear	Date:				
Under 27:					
☐ HPV/Gardasil vaccine	Date:				
☐ Chlamydia (urine) test	Date:				
Over 40:					
☐ Mammogram	Date:				
Men only: **Under 27:**					
☐ HPV/Gardasil Vaccine	Date:				
Over 40:					
☐ Abdominal ultrasound	Date:				
☐ PSA test	Date:				

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Do you currently see any other physicians?			
Physician:		Specialty:	
Physician:		Specialty:	
Physician:		Specialty:	
Physician:		Specialty:	
Physician:		Specialty:	
Physician:		Specialty:	
Physician:		Specialty:	
Are you up to date on:			
Tdap (tetanus, pertussis/whooping cough)	Date:		
HPV (Gardasil)	Date:		
Influenza (flu shot) Pneumonia – 23	Date:		
Pneumonia – 13 Shingles (Zostavax)	Date:		
HPV (Gardasil)	Date:		
Influenza (flu shot) Pneumonia – 23	Date:		
Are you up to date on the following:			
Colonoscopy (colon cancer screening	Date:		
Bone Density (osteoporosis screen)	Date:		
Mammogram (breast cancer screen)	Date:		
Pap smear (cervical cancer screen)	Date:		
Prostate cancer screen	Date:		

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The information provided in this questionnaire is true and complete to the best of my knowledge. I understand that the accuracy of the information I have provided is important to my physician and my healthcare team in order to develop an individualized care plan for me.

Patient or Representative Signature	Date	Time

Print Name	Relationship to Patient

Interpreter (if applicable)	Interpreter ID #	Date	Time

Physician Signature	Date	Time