Dera Health New Patient Registration/ Intake Form: Medical Information

Patient First Name: _____Middle:_____Last:_____
DOB:_____Preferred Name:_____Date:_____

It is important to complete this form, your answers on this form will help your provider better understand your health concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential.

Current Medical Providers			
Provider Name	*Specialty/Condition Treated*	Provider Name	*Specialty/Condition Treated*

Please describe any allergies to foods/medications and how each affects you:

Allergy	**Severity**	**Reaction Type**
	Select Option	
	Select Option	
	Select Option	
	Select Option	

List of All Medications*		
Name	Dose/Strength	Frequency

*Please include specific doses and when taken. If you don't know, please call your pharmacist to confirm. List all medications, including over the counter meds, vitamins, and marijuana (if used with a green card).

Dera Health • ph. (940) 977-1239 • Email Derahealth@gmail.com

Patient Full Name:_____DOB: _____

Family Medical History: If any of the following family members have been diagnosed with any major disease/illness/condition, please fill in as much information as you know.

Relationship	Alive? Y/N	Current Age/ Age at Death	Disease(s)/Illness(es)/Condition(s)
Father			
Mother			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Brother/Sister (circle)			
Brother/Sister (circle)			
Brother/Sister (circle)			
Brother/Sister (circle)			
Son/Daughter (circle)			
Son/Daughter (circle)			
Son/Daughter (circle)			
Other (please specify)			

Recent Immunizations					
	Date		*Date*		*Date*
Tetanus (Tdap)		Influenza		Pneumonia	
Shingles		Meningitis		HPV (Gardasil)	
For pediatric patients: Please provide a copy of immunization record/card at initial visit					

Medical History: Please check any current or past medical conditions/problems

☐	ADHD/ADD	☐	Diverticulitis	☐	Menopause
☐	Anemia	☐	Emphysema	☐	Migraine
☐	Anxiety	☐	Glaucoma	☐	Osteoarthritis
☐	Asthma	☐	Gonorrhea	☐	Osteoporosis/Osteopenia
☐	Bipolar Disorder	☐	Heart/Artery Disease	☐	Peptic (Stomach) Ulcer
☐	Blood Clots (DVT/PE)	☐	Heart Attack (MI)	☐	Polycystic Ovaries
☐	Blood Transfusion	☐	Heart Murmur	☐	Psoriasis
☐	Cancer (specify type below)	☐	Heartburn/GERD	☐	Rheumatoid Arthritis
☐	Cataract	☐	Hepatitis	☐	Seasonal Allergies
☐	Celiac Disease	☐	High Blood Pressure	☐	Seizure
☐	Chlamydia	☐	High Cholesterol	☐	Sexual Dysfunction
☐	COPD	☐	HIV/AIDS	☐	Sleep Apnea
☐	Crohn's Disease	☐	Hyperthyroidism	☐	Stroke
☐	Depression	☐	Hypothyroidism	☐	Substance/Alcohol Abuse
☐	Diabetes Type 1	☐	Kidney Stones	☐	Syphilis
☐	Diabetes Type 2	☐	Lupus	☐	Ulcerative Colitis

Others/Further details: _____

_____

Dera Health • ph. (940) 977-1239 • Email Derahealth@gmail.com

Patient Full Name:_____ DOB: _____

Preventative Care			
	Date		*Date*
Annual Physical		Eye Exam	
Colonoscopy		Mammogram	
Bone Density		Prostate Screening	
Dental Exam		Pap Smear	

//

(WOMEN ONLY) Menstrual and OBGYN History:

Date of last menstrual period or year of menopause: _____
Do menses occur monthly? ☐Y/☐N Frequency of menses: _____
Age of first menstrual period: _____ Currently on birth control? ☐Y/☐N
Type of birth control used: _____

Total Preg	Abortion	Miscarriage	Ectopic	Living Birth
#	#	#	#	#

Past Pregnancy Details					
	First	Second	Third	Fourth	Fifth
Date:					
GA Weeks					
Birth Weight					
Sex					
Delivery Type					
Preterm Labor	Select Y/N	Select Y/N	Select Y/N	Select Y/N	Select Y/N
Multiple Birth	Select Y/N	Select Y/N	Select Y/N	Select Y/N	Select Y/N

//

Social History: All questions contained in this questionnaire will be kept strictly confidential.

Tobacco Use- Please check current (C) or former (F)
☐None ☐C/☐F *Smoke every day* ☐C/☐F *Smoke some days* ☐C/☐F *Cigars daily* ☐C/☐F *Cigars some days* ☐C/☐F *Chewing tobacco every day* ☐C/☐F *Chewing tobacco some days* ☐C/☐F *Vape every day* ☐C/☐F *Vape some days*
If you ever smoked, how many packs/day average? ☐< ½ pack ☐½ pack ☐1 pack ☐1 ½ pack ☐2 packs ☐3+ packs
How many years total did you use a tobacco product?
If you currently use a tobacco product, are you ready to quit? ☐Yes ☐No
Would you like more information about the ASHLINE network ☐Yes ☐No

Alcohol Use- Please circle your response		
Cans of beer per week	Select option	
Glasses of wine per week	Select option	
Shots of hard liquor per week	Select option	
Mixed drinks w/ 0.5oz alcohol/week	Select option	

Dera Health • ph. (940) 977-1239 • Email Derahealth@gmail.com

Patient Full Name:_____DOB: _____

What is the highest grade/level of school/degree you have received? _____

How many days of moderate exercise, like a brisk walk, did you do in the last 7 days?_____
On those days, how many minutes on average do you exercise?_____

Caffeine Use- Please circle your response		
Cups of coffee/day	Select option	
Cups of tea/day	Select option	
Caffeinated sodas/day	Select option	
Energy drinks/day	Select option	

Are you currently sexually active? ☐Yes ☐No Age at first intercourse: _____
Sexual partners? ☐Male ☐Female ☐Both Number of partners in the last year:_____
How long have you been with your current partner? _____
Do you or your partner currently have any partners outside your relationship? ☐Yes ☐No

Have you ever used any illegal/street drugs? ☐Yes ☐No How long sober?_____
If you have ever used, please list all drugs used and duration: _____
_____

Past Surgical History: If you cannot remember specific details, please approximate.

Surgery	Date	Surgeon

Others/Further details: _____
_____

Do you have an advance directive (living will, MPOA)?☐Yes ☐No
Would you like information on how to register advance directive forms? ☐Yes ☐No

Are there any personal problems at home/work/school you would like to discuss? ☐Yes ☐No
Are there any cultural/religious concerns you have related to our delivery of care? ☐Yes ☐No
Are there any financial issues that impact your ability to manage your health? ☐Yes ☐No

Are there any vision problems which affect your communication? ☐Yes ☐No
Are there any hearing problems which affect your communication? ☐Yes ☐No
Are there any limitations to following verbal or written instructions? ☐Yes ☐No