Beth Israel University Hospital and Manhattan Campus for the Albert Einstein College of Medicine

Continuum Health Partners, Inc.

NEW PATIENT CONSULTATION FORM

Welcome to our office. Please fill out the first **four** pages.

Date_____

Name_____

Social Security Number_____-____-_____ **Date of Birth**_____ **Age**_____

Home Address_____

Home phone_____ **Cell phone**_____

Work phone_____ **Email address**_____

Occupation_____

Emergency Contact

Name_____ **Relation**_____ **Phone number**_____

Family Doctor_____ **Referring Doctor**_____

Address_____ _____

_____ _____

Phone_____ _____

Fax_____ _____

Other Referral Source_____

Main reason for today's visit _____

MEDICAL HISTORY

(Have you seen a doctor for any of the following illnesses?)

High blood pressure	□ YES	□ NO	
Heart disease	□ YES	□ NO	
High Cholesterol	□ YES	□ NO	
Diabetes	□YES	□ NO	
Kidney disease	□YES	□ NO	
Asthma or Lung disease	□ YES	□ NO	
Tuberculosis	□ YES	□ NO	
Liver disease or hepatitis	□ YES	□ NO	
Arthritis	□ YES	□ NO	
Bleeding disorder	□ YES	□ NO	
HIV	□ YES	□ NO	
Cancer	□ YES	□ NO	location_____
Bowel disease	□ YES	□ NO	(please circle): Crohn's disease, ulcerative colitis, polyps, irritable bowel syndrome, diverticulitis, chronic constipation

Other_____

Have you ever been **admitted to a hospital** for a serious illness (such as a stroke, heart attack, pneumonia, car accident)? □YES □NO
Please list:

SURGICAL HISTORY

Have you ever undergone **surgery**? □YES □NO
If yes, please list operations and dates:

Have you ever had a **colonoscopy**? □YES □NO
If yes, please list dates:

FAMILY HISTORY

Have any of your relatives had cancer? □YES □NO
Please list them and the type of cancer:

Have any of your relatives had Inflammatory Bowel Disease? □YES □NO

Please list any other significant family medical history (such as heart disease, diabetes, stroke, bleeding disorder, etc)

SOCIAL HISTORY
Do you smoke now? □YES □NO How much? _____
Have you ever smoked? □YES □NO
If yes, for how many years? _____ When did you quit?_____
Do you drink alcohol? □YES □NO
If yes, how much? _____ How often?_____
Have you used recreational drugs? □YES □NO
If yes, which ones?_____
When was the last time you used one/them? _____

Marital Status: □Single □Married/Partner □Widowed □Divorced
Sexual orientation: □Heterosexual □Homosexual □Bisexual □Transsexual
Has anyone in your family or home ever physically or verbally hurt you? □YES □NO
Do you need assistance with getting around(ie cane, wheel chair, etc)? □YES □NO
Do you exercise? □YES □NO

(For women only)
Are you pregnant or breast feeding? _____
Date of your last menstrual period: _____
How many children do you have? _____
How were they delivered?

Did you have any injury during delivery? □YES □NO

ALLERGIES
Are you **allergic** to anything (medications, foods, latex)? □YES □NO
If yes, please list:

MEDICATIONS:
-Please list all **medications and/or supplements** you are taking now with times and dosages:

REVIEW OF SYSTEMS
(Please check any symptoms you currently have)

Constitutional

□Fever/chills/night sweats □Unexplained weight loss □Fatigue/weakness

Head and Neck

□Headaches/migraines □Dizziness/lightheadedness □Change in vision
□Difficulty hearing/ringing in ears □Sleep apnea □Sinus congestion

Cardiovascular

□Chest pain/discomfort □Palpitations □Irregular heart beat
□Heart murmur □Leg/feet swelling (edema) □Shortness of breath

Respiratory

□Cough/wheeze □Blood with coughing

Blood/lymphatics

□Easy bleeding/bruising □Anemia □Received a blood transfusion at any time

Skin

□New skin lesion □Rash

Breast

□Breast lump □Nipple discharge

Endocrine

□Cold/heat intolerance □Excessive thirst

Psychiatric

□Sleep problems □Depression □Anxiety/stress

Neurological

□Numbness/tingling □Memory loss □Seizures

Musculoskeletal

□Muscle/joint pain □Back pain/injury □Muscle weakness

Genitourinary

□Leaking urine □Nighttime urination □Painful/bloody urination
□Difficulty/concern with sexual function □Genital sores

Gastrointestinal

□Abdominal/stomach pain □Nausea/vomiting
□Heartburn/reflux □Difficulty swallowing
□Bloating □Decreased appetite
□Constipation □Straining to move your bowels
□Diarrhea □Change in bowel movement/habits
□Blood from the rectum □Anal/rectal pain
□Anal itchiness □Anal swelling/lump/bumps
□Stool incontinence □Stool seepage/staining

PLEASE DO NOT WRITE ON THIS PAGE

HPI:

Bleeding:
Pain:
Mucus/Discharge/Pus:
Soiling:
Bowel Habits:
Constipation:
Straining:
Incontinence:
Incomplete defecation:
Tenesmus:

Weight Loss:
Abdominal Pain:

Anal receptive:
H/o Condyloma:
CD4:

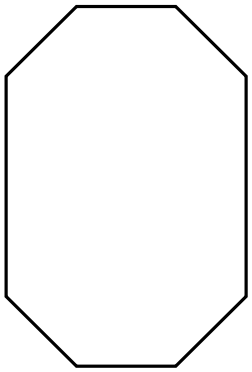
Physical Exam:

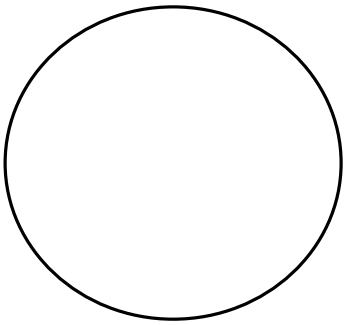
Vitals:

Abdomen:

DRE:

Proctoscopy/Flex Sig:





Plan: