ALBANY MED FACULTY PHYSICIANS
MORE THAN 350 EXPERTS PRACTICING WHAT THEY TEACH.

Place label Here
Patient Name

Clinical Nutrition
New Patient Form

Primary Care Physician
Name: Address:
Reason for today's visit?
Please describe your problem from the first sign/symptom, including location, severity, duration, and associated factors, etc.

Personal Diet History	
Age of first diet: Weight at puberty: ☐ Skinny ☐ Normal ☐ Chubby Weight at 20: Height at 20: Pre-marriage weight: Age: Ever lost or regained 20lbs? ☐ Yes ☐ No How many times?	Heaviest weight: When: Lightest weight: When: Do you consider yourself a "**BINGE EATER**"? ☐ Yes ☐ No Describe a typical binge below:

Pregnancies	Weight Gained	Weight Loss	Date/Year
1st			
2nd			
3rd			
4th			

Have you ever used the following methods for weight loss:							
Method	**Yes**	**No**	**When**	**Method**	**Yes**	**No**	**When**
Vomiting				Diet Pill/Prescription			
Water Pills				Diet Pills/Over the Counter			
Ipecac				Excessive Exercising			
Laxatives							

Please list all the diet programs you have previously attempted and approximate dates:		
Program/Date	Weight Loss	Time Weight Regained

Medications		
Name	Dosage	Frequency

Allergies	
Name	Reaction

Please list all Hospitalizations and Major Illnesses	
Date	Event

Social History

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Widowed	Current Living Arrangements: ☐ Alone ☐ Spouse/Significant Other ☐ Friend ☐ Parent ☐ Children ☐ Other Family
Occupation: Do you enjoy your work?	Recreational Activities: Hobbies:

	Never	Yes/What Kind	Amount/Years	Quit/When
Tobacco Use				
Alcohol Use				
Drug Use				

Caffeine Use:				
Coffee				
Soda				
Chocolate				
Have you ever been physically or sexually abused?				

Do you exercise? ☐ Yes ☐ No If yes, what type? _____

Times per week: _____ How long? _____

Family History Sheet:
Please answer and check off the boxes that apply to your family history:

	Mother	Father	Siblings/ How many ___	Children/ How many ___	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Spouse
Height									
Maximum Weight									
Minimum Weight									
Diabetes									
Heart Disease									
Elevated BP									
DVT/PE (blood clot)									
Stroke									
Arthritis									
Asthma									
Thyroid Disease									
Gout									
Eating Disorder									
Mental Illness									
Physical/ Sexual Abuse									
Ulcers									
Kidney Disease									
Cancer									
Alcohol/ Drug Abuse									
State of Health if Living/Age									
Cause of Death/Age									

Do you have any questions or issues you would like to discuss with the physician regarding family history?

Medical History

Have you ever experienced any of the following medical problems?

	Yes	No		Yes	No		Yes	No		Yes	No
Stroke			Eye Trouble			Rheumatic Fever			Blood Disorder		
Seizure Disorder			Pneumonia			Liver Disease			Blood Transfusion		
Unconsciousness			Emphysema			Gerd Esophageal Reflux			Broken Bones		
Anxiety/ Depression			Asthma			Gallbladder Disease			Arthritis		
Other Mental Illness			Sleep Apnea			Diverticulitis			Gout		
DVT/PE (Blood Clot)			High Blood Pressure			Kidney Stones			Urinary Tract Infection		
Skin Cancer			High Cholesterol			Kidney Disease			Venereal Disease		
Other Types of Cancer			Heart Mumur			Thyroid Disease			Breast Lump		
Radiation Treatment			Enlarged Heart			Anemia			Exposed to TB		
Glaucoma			Heart Attack			Diabetes			Hay Fever		

REVIEW OF SYSTEMS (TO BE COMPLETED BY THE PHYSICIAN) Check here if ROS balance is negative _____

Constitutional	
HEENT	
Cardiovascular	
Respiratory	
Gastrointestinal	
Gentourinary	
Musculoskeletal	
Neurological-Psychiatric	
Endocrine	
Hematologic/Lymphatic	
Allergic/Immunologic	
Integumentary	

Vitals	Temp	Pulse	Resp	HT	WT	BP

General Appearance

		Exam Normal	
Eyes	Conjunctivae/lids Pupils/Iris Ophthalmoscopic Exam		
ENMT	Ext. Ears/Nose Ext. Audo		

	Hearing Nasal Mucosa, Septum, Turbinetes Lips/Teeth/Gums Oropharynx		
Neck	Neck/Thyroid		
RESP	Resp effort Percussion of chest Palpation of chest Auscultation of lungs		
Cardio	Palpation of Heart Auscultation of Heart Examination of Carotid and Femoral arteries, abdominal aorta, pedal pulses, extremities for edema/varicosities		
Chest/Breasts	Breasts Palpation of breasts and axillary		
GI	Abdomen Liver and Spleen Hernia Anus, perineum/rectum Obtained stool sample		
GU	**MALE**: Scrotal contents Penis Digital rectal exam **FEMALE**: Ext. henitalia Urethra Bladder Cervix Uterus Adnexa/parmetria		
Lymph	Palpation of nodes in 2 or more areas Neck Axillac Groin Other		
Musculo	Gait and station Digits and nails One or more of the 6 areas Head and neck Spine, ribs and pelvis Right upper extremity Left upper extremity		
Skin	Skin and subcutaneous tissue Palpate skin and subcutaneous tissue		
Neuro	Test cranial nerves Deep tendon reflexes Sensation		
Psych	Description of judgement and insight Brief assessment of mental status Orientation to time place and person Recent and remote memory Mood and affect		

Documentation of Visit	Place Label Here

Assessment/Plan:

Referrals/Test Ordered

Medication Changes

50% of Visit Was Spent Counseling and the Following Was Covered:

Exam Requirements:

Comprehensive	2+bullets from 9 systems
Detailed	2+ bullets for 6 systems
	12+ bullets for 2 or more systems
Exp. Prob. Focused	6+ bulleted elements
Problem Focused	1-5 bulleted elements

Visit Times:

Consults	New Patients	Prolonged Services
99241 15 min	99201 10 min	99354 1st hour
99242 30 min	99202 20 min	99355 ea Add ½ hour
99243 40 min	99203 30 min	
99244 60 min	99204 40 min	
99245 80 min	99205 60 min	

RESIDENT/FELLOW

PHYSICIAN