EISENHOWER MEDICAL CENTER
NEW PATIENT PACKET

NEW PATIENT REGISTRATION FORM

Patient Information

First Name	Last Name	MI	Date of Birth (mm/dd/yyyy)
Address*	City	State	Zip
Please check primary phone number	Home Phone ☐ ( ) -	Work Phone ☐ ( ) -	Cell Phone ☐ ( ) -

Please complete the "Medical Record Release form" if you have estabished care outside Eisenhower so that we can have your medical records prior to your appointment

Other Name(s) Used		E-mail Address	
Gender: M ☐ F ☐	SSN/ National ID:	Preferred Language:	Driver's License:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	Preferred Contact: ☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal (MyChart)	Ethnicity: ☐ Declined to respond/ provide ☐ Hispanic/ Latino ☐ Non-Hispanic	Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other
Occupation:	Employer Name:	Employer Address:	Employer Phone Number:
Primary Care Provider:		Referring Provider:	

Responsible Party (Guarantor) ☐ **Same as patient (Self)**

First Name	Last Name	MI	Date of Birth (mm/dd/yyyy)
Address	City	State	Zip
Please check primary Phone	Home Phone ☐ ( ) -	Work Phone ☐ ( ) -	Cell Phone ☐ ( ) -
SSN/ National ID:	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact

First Name	Last Name	MI	Date of Birth (mm/dd/yyyy)
Address	City	State	Zip
Please check primary Phone	Home Phone ☐ ( ) -	Work Phone ☐ ( ) -	Cell Phone ☐ ( ) -

Primary Medical Insurance		**Secondary Medical Insurance**	
Insurance Company		Insurance Company	
Policy Holder Name		Policy Holder Name	
Date of Birth		Date of Birth	

EISENHOWER MEDICAL CENTER

Relationship to patient		Relationship to patient	
Group Number		Group Number	
Subscriber ID		Subscriber ID	

NEW PATIENT MEDICAL HISTORY	
Reason for visit: ☐ No concerns	☐ Establish care with new provider
1.	3.
2.	4.

Pharmacy Information

Preferred Pharmacy		***Secondary Pharmacy***	
Name		Name	
Address		Address	
Phone		Phone	
Fax		Fax	

Advanced Directive(s)

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy
Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	*Dosage*

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	*Year*	*Condition*	*Year*
☐ None		☐ High blood pressure	
☐ Acid reflux		☐ High cholesterol	
☐ Anemia (low blood count)		☐ Irritable Bowel Disease	
☐ Angina		☐ Irregular heart beat/ palpitations	
☐ Anorexia/ Bulimia		☐ Joint problems (Specify:_________________)	
☐ Anxiety / Panic Attacks		☐ Kidney problems (Specify:_________________)	
☐ Arthritis		☐ Liver problems	
☐ Asthma		☐ Migraine Headaches	
☐ Atrial Fibrillation		☐ Mobility problems	
☐ Bleeding Disorders/ Blood Clots		☐ Osteoporosis	
☐ Bronchitis		☐ Pneumonia	
☐ Cancer – (Type:____________________)		☐ Psychiatric problems	

EISENHOWER MEDICAL CENTER

☐ Chemical/ Alcohol dependency		☐ Prostate Problems	
☐ COPD/ Emphysema		☐ Seasonal allergies	
☐ Crohn's Disease		☐ Sexually transmitted disease	
☐ Dementia/ Alzheimer's		☐ Skin condition (Specify:_________________)	
☐ Depression		☐ Stroke/ TIA	
☐ Diabetes/ High Blood sugar		☐ Seizure Disorder/ Epilepsy	
☐ Gout		☐ Thyroid Disease	
☐ Gallbladder Disease		☐ Tonsillitis	
☐ Gynecological problems (Specify:________)		☐ Tuberculosis	
☐ Heart disease/ Heart Attack		☐ Ulcers	
☐ Hepatitis		☐ Urinary problems (Specify:_______________)	
☐ Other:		☐ Other:	
Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	***Year***	***Surgical Procedures***	***Year***
☐ None		☐ Gastric Bypass/ Weightloss surgery	
☐ Angioplasty		☐ Heart stent(s)	
☐ Angioplasty w/Stent		☐ Hemorrhoidectomy	
☐ Appendectomy		☐ Hernia Repair (Type:_____________________)	
☐ Arthroscopy Knee		☐ Hip Replacement	
☐ Back Surgery		☐ Knee Replacement	
☐ Biopsy (Type:_____________________)		☐ LASIK	
☐ Carotid Artery Surgery		☐ Pacemaker Insertion	
☐ Coronary artery bypass (heart bypass)		☐ Small Bowel Resection	
☐ Carpal Tunnel Release		☐ Thyroidectomy	
☐ Cataract surgery		☐ Tonsillectomy	
☐ Colon surgery (Type:___________________)		☐ Skin graft	
☐ Gall bladder removal		☐ Other:_________________________________	
Male Only			
☐ Prostate surgery		☐ Other	
☐ Vasectomy		☐ Other	
☐ TURP (Trans-urethral resection of Prostate) Vasectomy			
Female Only			
☐ Augmentation Mammoplasty		☐ Mastectomy	
☐ Bilateral Tubal Ligation		☐ Myomectomy	
☐ Breast Biopsy		☐ Reduction Mammoplasty	
☐ Cesarean Section		☐ TAH/BSO	
☐ D and C		☐ Vaginal Hysterectomy	
☐ Hysterectomy		☐ Other	
Prior Hospitalizations			

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Year	*Reason*	*List providers involved in your care*	*Year*	*Reason*	*List providers involved in your care*

Health Maintenance – Check if you have received the following, and date of most recent exam.

Exam	*Date*	*Exam*	*Date*
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Social History

Do you have children? ☐Yes ☐No | How many? | Female(s) | Male(s)

Tobacco Use

☐ None ☐ Former/Year quit:	☐ Daily ☐ Weekly ☐ Less Number of cigs/day:__________	☐Chewing ☐Cigar ☐Smokeless Brand:	☐ Pipe ☐ Cigarette

Alcohol Use

☐ None ☐ Former/Year quit:	☐ Daily ☐ Weekly ☐ Less Number of drinks/week:__	☐Beer ☐Liquor	☐ Wine ☐ Other:

Recreational drugs:

☐ None ☐ History of injection drug use ☐ Past / Current use (Specify:___)

Exercise Activity

☐ Moderate ☐ Vigorous ☐ Sedentary

Days/Week:

Sleep Pattern:

☐Changes ☐ No Changes

Caffeine Use

☐ None ☐Daily ☐ Weekly ☐ Less

Number of drinks/week:_______

Diet: ☐ Diabetic ☐ Heart Healthy Meat and ☐Potatoes ☐Vegetarian ☐Other:___________

Have you had a fall in the past year? ☐ Yes ☐ No