New Patient Intake Form

Patient Name: ___________________________________ Date of Birth: _____________________

Have you ever been to a Riverview Health facility before? Yes ☐ No

Tobacco use? ☐ Yes ☐ No If yes, how many times per day? _____ If yes, for how many years? _____

Alcohol use? ☐ Yes ☐ No If yes, how much and frequency? ____

CHECK ANY CURRENT CHRONIC CONDITIONS BELOW

	No Significant Medical History		**COPD/Emphysema**		**IBS**
	Anxiety		**Dementia**		**MRSA**
	Arthritis		**Depression**		**Osteoporosis**
	Asthma		**Diabetes**		**Pancreatitis**
	Atrial Fibrillation		**DVT/PE**		**Peptic Ulcer Disease**
	Bleeding Diathesis		**GERD**		**Peripheral Vascular Disease**
	CA - Breast		**Headaches**		**Psychosis**
	CA - Colon		**Hepatic Failure**		**Renal Insuff/Failure**
	CA - Lung		**HIV/AIDS**		**Seizure Disorder**
	CA - Other		**Hyperlipidemia**		**Substance Abuse**
	CAD (coronary artery disease)		**Hypertension**		**Urinary Tract Stones**
	Cerebrovascular Disorder		**Hyperthyroidism**		**VRE**
	CHF (congestive heart failure)		**Hypothyroidism**		**Vtach/Fib/Arrest**
	C-diff				

Other:

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Patient's Surgical History

Year	Operation/Illness	Name of Hospital	City & State

Other Patient Information

Allergies to Any Medication(s) **□ Yes □ No**

If yes, please list: ____

Allergies to Any Dye(s) or Lotion(s) **□ Yes □ No**

If yes, please list: ____

Please list any medications that you are currently taking (include prescriptions, herbals vitamins, and over-the-counter medications, along with dosage amounts). If more space is needed, please use back side of form.

Medication/Prescription Name	Dosage Amount

Family History

Please place a check (✓) in the appropriate box below, if any of the listed family members have any of the following medical conditions.

	Father	Mother	Brother	Sister	Spouse	Children
Allergies						
Asthma						
Anemia						
Arthritis						
Cancer						
Diabetes						
Epilepsy						
Eye Disease						
Gout						
High Blood Pressure						
Heart Disease						
Reflux Disease						
Living Family Member						
Deceased Family Member						

Other:

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