New Patient Worksheet

Thank you for choosing the **Rochester Medical Center** for your medical care. Please complete bring it to your appointment. You can also mail it to us:

ATTN: Medical Records
Mail: PO Box 82177, Rochester, Michigan 48308

Last Name:_____

First Name:_____

Middle Name:_____

Date of Birth_____ Last 4 SSN _____

Home Address_____

Home Phone:_____ Cell phone:_____

Email_____

Emergency Contact Name & Relation: _____

Emergency Contact Phone Number: _____

Would you like access to our **Patient Portal** to access your medical records? Y/N

Who is your current Primary Care Doctor _____

******Please have all of your previous medical records faxed to the Rochester Medical Center if you are being seen for primary care. Fax 248-656-3152***

Please list all other physicians you see: *(*Please include their name and specialty and the condition they are treating).

_____

_____

_____

_____

Reason for visit: What health issues do you want to focus on at your visit?

What are your current medical conditions? (Heart disease, high blood pressure, high cholesterol, diabetes, etc.)

Medical History: Please list any major past illnesses, hospitalizations (include year or date if known).

Surgeries: List any past surgeries (and what year/date).

Abnormal PAP tests/Other GYN Procedures: (For RMC Patients only):

Family History: Have your close relatives, parents, siblings, children, or grandparents had any of the following?

Heart attack, Angina/Chest pain, Congestive Heart Failure, Coronary Artery Bypass Surgery, Stroke, High blood pressure, Blood clots (DVT, or Pulmonary Embolism), High Cholesterol, Diabetes, Thyroid disease, Breast cancer, Other Cancer--what type?, Kidney Disease, Lupus, Rheumatoid Arthritis, Asthma, Mental Health disorder, Substance Abuse.

If yes, which relative? And at what age were they diagnosed?

_____

_____

_____

_____

Do you have Medication allergies? □ Yes □ No

If yes, please list the medication(s) and your reaction.

_____

_____

_____

_____

Please list all prescribed and over-the-counter medications you take regularly. Please include all supplements, vitamins or herbal products. List the dose and when you take them:

_____

_____

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_____

Do you use alcohol, caffeine, energy drinks, tobacco, or any recreational drugs? If so how often? If you have a history of smoking, how many packs per day and for how many years did you smoke?

_____

_____

_____

Please complete the chart below.

Health Maintenance	**Date:**
Flu Vaccine	
Pneumonia Vaccine	
TDAP	
Shingles Vaccine	
Gardasil Vaccine	
Colonoscopy	
Mammogram (Female)	
Prostate Specific Antigen (Male)	
Pap/Pelvic Exam (Female)	
Bone Density	
Pulmonary Function Testing	
Stress Test	
Hepatitis Panel	
Diabetic Eye Exam (Diabetic)	
Diabetic Foot Exam (Diabetic)	
Hemoglobin A1C (Diabetic)	
Date of Last Complete Physical	

Personal and Professional Development: What is your current or past occupation?

_____

❑ Employed ❑ Unemployed ❑ Disabled ❑ Retired ❑ Care-taking ❑ Other

Have you had hazardous environmental or occupational exposures (chemicals, dust, mold, paints, radiation)? If yes, please describe:

_____
_____
_____
_____

Review of Symptoms: Are there any other medical issues you would like to address?

_____
_____
_____
_____
_____
_____

Is there anything else that would be helpful for us to know about you?

_____
_____
_____