



NEW PATIENT EVALUATION

Name: _____

DOB: _____

Please list all other Physicians that you would like to have a copy of your medical information:

Pharmacy you typically use: _____ Phone Number: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Do you currently have a: **Living Will:** Yes___ No___ **Durable POA:** Yes___ No___ **DNR:** Yes___ No___

*If yes, please provide a copy

Current Medications (Including over the counter, dose and frequency)

- | | |
|-----------|-----------|
| 1.) _____ | 5.) _____ |
| 2.) _____ | 6.) _____ |
| 3.) _____ | 7.) _____ |
| 4.) _____ | 8.) _____ |

Allergies (Including adverse reaction if known): _____

Social History

Marital Status: () Single () Married () Widowed () Divorced () Separated

Occupation: _____ Retired? Yes / No

Exposure to Hazardous Materials? Yes / No () Asbestos () Benzene () Lead () Radiation Other _____

Alcohol Use: () Never () Rare () Moderate () Daily # _____ drinks per day/week

Tobacco Use: () Never () Quit _____ months / years () Current Smoker # _____ packs per day # _____ years

() Cigarettes () Cigars () Chewing Tobacco () Pipe () e-Cigarettes () Recreational Drug Use _____

Please indicate your activity level: () Sedentary () Daily Activities () Exercise Occasional / Regular / Extensive