

New Patient

TODAY'S DATE: _____

JOSE M BAEZ, MD, LLC

Patient name				Date of birth		Age		Gender		
Date of Last Wellness		(Medicare B eligibility date)			Race			Primary Language Spoken		
BP	HR		RR	HT	BMI		WEIGHT		TEMP	
SOCIAL HISTORY										
TOBACCO?	Never	Current smoker		No. years smoked?		Packs per day		Year Quit	Other tobacco	
ALCOHOL?	Never	Few times/year		1-2 per day		3 or more per day		Past history of abuse...Year quit:		
CAFFIENE?	Never	Occasional		Daily		DIET:				
DESCRIBE ANY HISTORY OF DRUG USE OR ABUSE				EXERCISE ROUTINE						
Marital Status (Circle one) S M W D				Number of pregnancies: _____ Sexual partner preference: M F			Number of children _____ Living _____ Deceased			
Highest level of education completed		Current occupation				If retired, what type of work did you do?				
HOME ENVIRONMENT	Private home		Assisted Living		Nursing Home		Other			
FUNCTIONAL / SAFETY SCREEN (65 AND OVER)										
Do you need someone else to drive for you?				Yes	No	Do you have any difficulty feeding yourself?			Yes	No
Do have difficulty with mobility? (getting out of bed, walking, or getting in/out of a chair)				Yes	No	Do you have difficulty getting dressed?			Yes	No
Do you have difficulty with grooming? (combing hair, shaving, brushing teeth)				Yes	No	Do you need help with your shopping?			Yes	No
Do you need help with housekeeping?				Yes	No	Do you need help managing your money?			Yes	No
Do you need help managing your medications?				Yes	No	Do you need help using the telephone?			Yes	No
Do you have stairs in your home without handrails or with poor lighting?				Yes	No	Do you have difficulty with balance?			Yes	No
Have you noticed any hearing difficulties?				Yes	No	Does your bladder sometimes leak?			Yes	No
Do you have a living will or advanced directive?				Yes	No	Have you had days where you felt very little pleasure in Activities during the past 2 weeks I Yes I No				
						Have you felt down, depressed or hopeless I Yes I No				
Do you have regular or frequent pain?		None	Mild		Moderate or occasional			Continuous	Severe	
Have you fallen DURING THE LAST 12 MONTHS?				No		Only once, no injury		Two or more times		Injury that required medical attention

NAME _____

DATE _____

PROVIDER LIST (Please list all used /seen during past year)			
Physicians	Reason	Other Physician / Therapist / Chiropractor	Reason
Medical Supplier / DME company		For	
Local Pharmacy		Mail Order Pharmacy	

MEDICATION LIST (List all prescription, non-prescription, supplements, herbals, other.)		
Name of Medication <i>Example: Ibuprofen</i>	Strength or Dose <i>200mg</i>	Frequency and route <i>2 tablets by mouth 3 times a day</i>

ALLERGY LIST			
ALLERGY	REACTION	ALLERGY	REACTION

VACCINATIONS					
	YEAR		YEAR		YEAR
Influenza (Flu Shot)	<input type="text"/>	Pneumovax 23 (Pneumonia)	<input type="text"/>	Tetanus / pertussis (TDaP)	<input type="text"/>
Shingles	<input type="text"/>	Prevnar 13 (Pneumonia)	<input type="text"/>	Tetanus / NO pertussis (dT)	<input type="text"/>
Hepatitis A	<input type="text"/>	Hepatitis B	<input type="text"/>	Gardasil	<input type="text"/>

SCREENING TESTS				
TEST	NONE	DATE IF DONE	DR. OR FACILITY	(FOR OFFICE USE) RECOMMENDED
Colonoscopy				
Stool test for blood				
Pap smear / pelvic exam				
Mammogram				
Bone Density				
Prostate cancer screen				
Electrocardiogram (EKG)				
Eye exam / Glaucoma screen				
Hearing evaluation				
Hepatitis C Screening				
Abdominal Aortic Screening (abdominal ultrasound)				

For office use:

COUNSELING:

X		Education	Recommended	Scheduled
	Diet / Nutrition			
	Advance Directive			
	Smoking Cessation			
	Alcohol Use			
	Home Safety			
	Exercise			
	Vaccines			
	Diabetic Education (DSMT)			
	Safe Sex Practices			
	Aspirin therapy			
	Calcium and / or vitamin D therapy			
	Cognitive evaluation			
	Driving assessment			
	Social Services			

BRING TO OFFICE APPOINTMENT