Vibrance

Internal Medicine & Wellness Center

Myriam Daniel, MD

New Patient Form

Patient Name: ______________________ **Date:** __________

DOB : __________

Were you referred by someone? ___ Yes ___No

If yes, whom should we thank? ______________________________________

If no, how did you hear about us? ____________________________________

Please answer the following questions to help us provide you with the best health care.

Primary Reason for Visit:

1. To establish care : ___________________________
2. Problem: __________________________________
3. Medication Refills: __________________________

Allergies Drug or Non Drug Related (Food, etc.) (If none please circle none) NONE

Drug	Reaction

Do you see any specialist?

Chiropractor: _______________

Dermatologist:_______________

ENT: _______________________

Gastroenterologist:___________

Nephrology: ________________

Orthopedic: ________________

Oncologist: ________________

OB/GYN: __________________

Psychiatrist/Psychologist: ___________

Current Medications (Include over the counter meds, vitamins, herbs, laxatives, etc.)

Medication Name	Strength or Dose	Frequency

Past Medical History – Please include the **YEAR** diagnosed:

_______Allergies
_______Anemia
_______Anxiety
_______Arthritis
_______Asthma
_______Atrial Fibrillation
_______Blood Clots
_______Cancer
_______Coronary Artery Disease
_______COPD
_______Crohn's Disease
_______Depression
_______Disease Diabetes
_______Gallbladder
_______GERD (reflux)
_______Heart Attack
_______Hepatitis C
_______High Blood Pressure
_______High Cholesterol
_______Irritable Bowel Disease
_______Liver Disease
_______Migraine Headaches
_______Osteoarthritis
_______Osteoporosis
_______Peptic Ulcer Disease
_______Prostate Enlargement
_______Renal Disease
_______Seizure Disorder
_______Thyroid Disease
_______Tuberculosis

Past Surgical History- Please include **YEAR:**

_______Angioplasty
_______Appendectomy
_______Arthroscopy Right Knee
_______Back Surgery
_______Bowel Resection
_______Breast Augmentation
_______Breast Biopsy
_______Breast Reduction
_______Carpal Tunnel Release
_______Cataract Extraction
_______Cesarean Section
_______D & C
_______Gallbladder Removal
_______Gastric Bypass
_______Heart Surgery
_______Hernia Repair
_______Hysterectomy
_______Knee Replacement
_______Lasik
_______Liver Biopsy
_______Mastectomy
_______Pacemaker
_______Removal of Fibroids
_______Thyroidectomy
_______Tubal Ligation
_______Other

Family History- Please List **RELATION** and **AGE** of Onset and/or Death:

Alcoholism _______________

Attention Deficit_______________

Asthma_______________

Alzheimer's_______________

Blood Disease_______________

Cancer_______________

Depression_______________

Diabetes_______________

Heart Disease_______________

High Cholesterol_______________

High Blood Pressure_______________

Irritable Bowel Disease _______________

Kidney Disease_______________

Lupus _______________

Mental Illness_______________

Migraines_______________

Obesity_______________

Osteoarthritis_______________

PVD____________________________ Stroke__________________________

Seizure Disorder_________________ Other ___________________________

Social History:

Occupation____

Any Work Restrictions______________________________

Full Time________ Part Time _______ Retired ________/ When ________

Marital Status ____________________ Children: Yes____ No_________

#Boys_____ #Girls______

Tobacco Use Yes____ No____ Former_______ Packs/Day_______

Alcohol Use Yes____ No____ Former______ Drinks/Day_______

Caffeine Use Yes____ No____ Type________ Cups/Day_____

Exercise Yes____ No____ Type___________ Days/Week______

Immunizations- Please list **DATE** of last; or provide a copy of Immunization Record

________Hepatitis B ________Pneumonia Vaccine

________HPV ________Tetanus (Td or TdaP)

________Influenza (flu) ________Varicella (Chicken Pox)

________MMR ________Zoster (Shingles)

Health Maintenance- Please list the **DATE** of most recent:

Colonoscopy___________ Mammogram ____________ Pap ______

Labs __________________ Bone Density ____________ PSA______

Advanced Directives in Place:

_____None _____Do Not Resuscitate ________Living Will

_____Durable Power of Attorney ______Healthcare Proxy

I ____________________ (print name) agree that the information provided is accurate to best of my knowledge. I also understand that additional records may be requested from my previous physician to ensure I receive the best medical care.

Signature: _________________________________ **Date:** ____________