MRN #:_____ FIN #:_____

Welcome to Einstein Physicians Montgomery! We are pleased you have chosen us for your healthcare needs. We look forward to getting to know you and taking care you! Please complete the following medical history forms.

PATIENT DEMOGRAPHICS:

Name: _____ Date of Birth_____

Address (street/city/state/zip): _____

_____

Best phone number to contact you? (circle: cell/ home/ work) _____
Can we leave a message with important or private information, including bloodwork or imaging results?
____yes ____no

Next best phone number to contact you? (circle: cell / home / work) _____
Can we leave a message with important or private information, including bloodwork or imaging results?
____yes ____no

What is your preferred pharmacy?
Name: _____

Location: _____

(T): _____

Do you use a mail order pharmacy for long-term prescriptions? _____YES _____NO

Name: _____

Location: _____

(T): _____

What is your preferred Lab?
Einstein Quest LabCorp Other
(If hospital employee, we recommend Einstein)

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ALLERGIES:

Do you have any allergies or sensitivities to medications or medical products (i.e. latex?)

Yes: _____ No:_____

If yes, please list what you are allergic to and the reaction you had:

Allergy To:	**Reaction**

CURRENT MEDICATIONS:

Please list your current medications (including over-the-counter medications and vitamins):

Medication	**Dose**

SOCIAL HISTORY:

Do you currently use tobacco of any kind? _____YES _____NO

What type(s) of tobacco do you/have you used?

_____ Cigarette _____Pipe _____Cigar _____Chewing Tobacco

Other: _____

Are you a:

____ Current smoker daily? (Have smoked at least 100 cigarettes during your lifetime and still smoke daily)

____ Current smoke sometimes? (Do not smoke every day and have smoked fewer than 100 cigarettes in your lifetime)

____ Former smoker? (Smoked at least 100 cigarettes in your lifetime, but do not currently smoke)

____Never smoked? (have not smoked 100 or more cigarettes in your lifetime)

How much do/did you smoke per day?:_____

What age did you start smoking?:_____ What age did you stop smoking?:_____

Do you drink alcohol of any kind? _____YES _____NO _____PAST

If yes, please indicate what kind(s) of alcohol: ____Beer ____Wine _____Liquor

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How often do you drink alcohol?

___1-2 times per year
___1-2 times per month
___ 1-2 times per week
___3-5 times per week
___Daily
___several times per day

Do you have any history of substance abuse (i.e. alcohol, drugs)?: ___YES ____NO
If yes, what kind:_____
Are you currently using this/these substances? _____YES _____NO
If yes, which ones and with what frequency? _____
_____

What is your current employment status?:
___Employed
___Retired
___Student
___Unemployed
___Caretaker
___Disabled

What do/did you do for work? _____

Students:
Name of School: _____
Grade Level: _____

What is your highest level of education?
___Elementary
___Middle School
___High School
___Some College
___College Degree
___Post-graduate

With whom do you live?
___Alone
___With children
___With spouse/significant other
___With mother
___With father
___With siblings
___Other (please qualify): _____

Have you ever felt unsafe in your home?: ____YES ____NO

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What type of diet do you follow?
___Regular (none)
___Calorie Restricted
___Diabetic
___Vegetarian
___Other (please qualify):_____

Do you exercise? _____YES _____NO
If yes, how often do you exercise?
___1-2 times per week
___3-4 times per week
___5-6 times per week
___Daily
What type of exercise do you do?
___ Walking
___ Running
___ Cycling
___ Aerobics
___Weight Lifting
___Swimming
___ Yoga
___ Other (please qualify):_____
How would you rate your physical condition today? ___Excellent ___Good ___Fair ___Poor
Are you having any pain today? ____YES ____NO

PAST MEDICAL HISTORY:
Please list all medical conditions you have been diagnosed with or treated for:

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FAMILY MEDICAL HISTORY:

Have any of your family members have ever had any of the following:

High Blood Pressure:	**Heart Disease:**	**Stroke:**	**Diabetes:**	**Cancer:**	**Osteoporosis:**
Father	Father	Father	Father	Father	Father
Mother	Mother	Mother	Mother	Mother	Mother
Brother	Brother	Brother	Brother	Brother	Brother
Sister	Sister	Sister	Sister	Sister	Sister
Brother	Brother	Brother	Brother	Brother	Brother
Sister	Sister	Sister	Sister	Sister	Sister
Grandparents	Grandparents	Grandparents	Grandparents	Grandparents	Grandparents
All Family	All Family	All Family	All Family	All Family	All Family

Glaucoma:	**Bleeding disease:**	**Anxiety, depression, etc.):**	**Drug/ alcohol addiction:**	Other:
Father	Father	Father	Father	
Mother	Mother	Mother	Mother	
Brother	Brother	Brother	Brother	
Sister	Sister	Sister	Sister	
Brother	Brother	Brother	Brother	
Sister	Sister	Sister	Sister	
Grandparents	Grandparents	Grandparents	Grandparents	
All Family	All Family	All Family	All Family	

PAST SURGICAL/PROCEDURAL HISTORY:

Please list any surgical procedures you have ever had and their approximate date:

Procedure **Date**

_____

_____

_____

_____

_____

_____

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REVIEW OF SYSTEMS:

Check ANY POSITIVE symptoms or problems you have experienced in RECENT MONTHS:

	Yes	No
Fevers		
Chills		
Weight Loss		
Weight Gain		
Changes in vision		
Double Vision		
Light sensitivity		
Change in hearing		
Congestion		
Sore Throat		
Difficulty Swallowing		
Dentures		
Shortness of breath		
Cough		
Wheezing		
Chest pain, pressure, tightness		
Palpitations		
Swelling in legs		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Heartburn		
Abdominal Pain		
Pain with urination		
Blood in urine		
Urinary frequency		
Genital discharge		
Easy bruising or bleeding		
Excessive thirst		
Heat or cold intolerance		
Joint Pain		
Muscle pain		
Pain in legs when walking		
Skin rashes		
Abnormal skin lesions: moles, growth, etc		
Balance problems		
Numbness or tingling (especially in feet)		
Headaches		
Anxiety		
Depression		

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Women		
Age when you started menstrual cycles?		
Age when you stopped menstrual cycles?		
Are you having regular menstrual cycles now?		
How many times have you been pregnant?		
How many living children do you have?		
Have you ever had an elective termination of pregnancy (abortion)?		
Have you ever had a miscarriage?		
Could you be pregnant now?		
Any breast discharge not related to pregnancy or nursing?		
Men		
Prostate or urinary problems?		
Loss of sexual desire or erectile dysfunction?		

Provide most recent dates for the following:	Date	Performed Where?	Result?
Eye Examination (Eye Doctor)			
Podiatrist Visit (Foot Doctor)			
Colonoscopy			
Mammogram			
Pneumonia Vaccination			
Influenza Vaccination (Flu shot)			
Tetanus Vaccination (Td, Tdap, "whooping cough shot")			

Depression Screening (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following: (Check the appropriate box to the right)	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleep too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				

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6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				
	Not at all	**Somewhat difficult**	**Very Difficult**	**Extremely Difficult**
If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people				

PHQ-9 SCORE = _____ (to be scored by medical staff)

(Score 1-4 = Minimal depression; 5-9= Mild depression; 10-14= Moderate depression; 15-19= Moderately severe depression; 20-27= Severe depression)

✓	Recent Fall History	HOW DID YOU FALL? Circle all that apply					
	NO FALLS in past year						
	1 - 2 FALLS in past year	Trip	Slip	Dizziness	Lost balance	Leg/s gave way	Other
	3 OR MORE FALLS in past year	Trip	Slip	Dizziness	Lost balance	Leg/s gave way	Other

Do you feel unsteady when standing or walking?	❑ Yes	❑ No
Do you worry about falling?	❑ Yes	❑ No

Do you have a living will, advanced directives, healthcare proxy, or healthcare power of attorney?
___YES ___NO

If no, are you interested in information about the above items?
____YES ___NO

Patient Signature:_____Date:_____

Provider
Signature: _____ Date: _____