EID: _____
Insurance: _____
_____
_____

Wake Forest™ Baptist Health

Ralph Lauren Onsite Care Clinic
New Patient Form

Name:_____(last)_____(first)_____(middle initial)
Name you prefer being called:_____ Date of birth:_____/_____/_____
Address:_____ City: _____ Zip: _____
Phone number:_____ (home) _____ (mobile)
Email:_____

Medical History:

Diabetes	No	Yes	
High Blood Pressure	No	Yes	
Cancer	No	Yes	If yes, type: _____
Heart Trouble	No	Yes	Explain: _____
Stroke	No	Yes	

Number of pregnancies: _____ Live births: _____

Other Medical History (list on back if need more space):

_____
_____
_____

Prior Surgeries / Hospitalizations / Serious Injuries: What year?

_____
_____
_____

Current medications (*** *please bring all medications with you to your appointment*):

Name of medication	Dosage	How many times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to medications:

Name of medication	Type of reaction
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Do any <u>blood relatives</u> (primarily interested in grandparents, parents, brothers, sisters, and children) have a history of the following? If so, who?

			Relationship				*Relationship*
Breast cancer	No	Yes	_____	High blood pressure	No	Yes	_____
Colon cancer (or polyps)	No	Yes	_____	Strokes	No	Yes	_____
Prostate cancer	No	Yes	_____	High cholesterol	No	Yes	_____
Other cancer	No	Yes	_____	Osteoporosis	No	Yes	_____
Diabetes	No	Yes	_____				
Early heart attacks (40's or 50's)	No	Yes	_____				

Are there any other illnesses that run in your family? _____

_____

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Social History

married____ (year____) single___ divorced___ separated____ widowed____ other relationship____
# of children (and ages):_____ # of grandchildren:_____
Occupation:_____
Have you ever smoked cigarettes, cigars or vape?_____ Do you currently smoke/vape?_____
If not, when did you quit?____ If so, how many packs a day?____ Have you ever tried to quit?_____
Use of alcohol: Never___ Yes ____ If yes, what type (wine, beer, liquor)_____ Avg. # drinks per week __
Do you exercise regularly?____ How many times per week?_____ What activities?_____
Are you currently sexually active? Yes___ No___ Sexual preference: Female Male Both
Do you have any risk factors for HIV (AIDS) or Hepatitis (blood transfusions, i.v. drug use, high risk sexual exposure, multiple sexual partners) No____ Yes____
What are your hobbies?_____
Do you have a support system? (community group, church, etc.)_____

Review of Systems

Do you currently have trouble with any of the following <u>on a regular basis</u>?

<u>General:</u>		
Good general health lately	No	Yes
Recent weight change	No	Yes
Fever/chills/night sweats	No	Yes
Fatigue	No	Yes
Sleep problems	No	Yes
Loss of appetite	No	Yes
<u>Skin:</u>		
Rash	No	Yes
Itching	No	Yes
Suspicious lesions or spots	No	Yes
Hair loss	No	Yes
<u>Cardiovascular:</u>		
Chest pain	No	Yes
Palpitations/irregular heart beat	No	Yes
Shortness of breath lying flat	No	Yes
Swelling of legs	No	Yes
Thigh or calf pain with walking	No	Yes
<u>Allergic/Immunologic:</u>		
Hay fever	No	Yes
Hives	No	Yes
Food allergies	No	Yes
<u>Hematologic/Lymphatic:</u>		
Easy bruising or bleeding	No	Yes
Enlarged glands or lumps	No	Yes
<u>Neurologic:</u>		
Frequent headaches	No	Yes
Localized weakness	No	Yes
Numbness	No	Yes
Lightheaded or dizzy	No	Yes
<u>Eyes:</u>		
Vision difficulty	No	Yes
Concerns about eyes	No	Yes
<u>Psychiatric:</u>		
Depresson	No	Yes
Frequently sad or blue	No	Yes
Loss of interest in activities	No	Yes
Anxiety/nervousness	No	Yes
<u>Endocrine:</u>		
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes

<u>Respiratory:</u>		
Frequent cough	No	Yes
Coughing up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
<u>Ears/Nose/Throat:</u>		
Hearing difficulty	No	Yes
Sinus problems	No	Yes
Nose or throat concerns	No	Yes
<u>Gastrointestinal:</u>		
Abdominal pain or heartburn	No	Yes
Change in bowel patterns	No	Yes
Trouble swallowing	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Nausea or vomiting	No	Yes
Black tarry stool	No	Yes
Blood in stool	No	Yes
<u>Musculoskeletal:</u>		
Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Muscle pain	No	Yes
Back pain	No	Yes
<u>Genitourinary:</u>		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Sexual difficulty or concerns	No	Yes
Female only:		
Do you still have menstrual cycle?	No	Yes
If no, what was age at time of last menstrual cycle	_____	
If yes, date of last menstrual cycle	_____	
Irregular menstrual cycles	No	Yes
Hot flashes	No	Yes
Breast pain or discharge	No	Yes
Male only:		
Trouble initiating stream	No	Yes
Weak urine stream	No	Yes

Preventive Services

Have you ever had the following tests? If so, when was it last done?

Mammogram	No	Yes	Year _____	Hearing testing	No	Yes	Year _____
Breast exam	No	Yes	Year _____	Tetanus shot	No	Yes	Year _____
PAP smear	No	Yes	Year _____	Gardasil	No	Yes	Year _____
PSA (prostate)	No	Yes	Year _____	Pneumonia vaccine	No	Yes	Year _____
Colonoscopy	No	Yes	Year _____	Flu shot	No	Yes	Year _____
Bone density testing	No	Yes	Year _____	Zostavax	No	Yes	Year _____
Expert eye exam	No	Yes	Year _____	Other vaccines _____			

If you are over 65 please answer the following:

Do you have any hearing impairment? Yes No

If you answered yes do you wear hearing aids? Yes No

Have you fallen within the last 6 months? Yes No

If you answered yes, when ? _____

Do you have any difficulty with daily tasks at home? Yes No

Please list any difficulties_____

Advanced Care Planning

Do you have a health care power of attorney? Yes No

Do you have a living will? Yes No

Do you have a MOST, or SOTO order? Yes No

Would you like help preparing advanced directives? Yes No

Other health care providers you currently see:

Name	Specialty
_____	_____
_____	_____
_____	_____

Anything else you would like for your health care provider to know about you?

_____

_____

_____

_____

_____

_____

This information will be very helpful to us at your initial visit. Please either:

1) bring this with you to your appointment -OR-
2) drop this off at the clinic before your appointment

In order for us to make the most efficient use of the time for your visit, please arrive 15 minutes before your scheduled appointment time so you can be registered. Thank you.

Weight: _____ Height: _____

Blood Pressure: _____ Temperature: _____ HR: _____ O2: _____

Vision: R:_____ L:_____ BL:_____