ColumbiaDoctors

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Preferred Phone: _____ Email: _____ Gender: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____ Patient Marital Status: _____
Occupation: _____ Employer: _____
Primary Care Provider (PCP): _____ PCP Phone: _____
PCP Address: _____
Preferred Pharmacy: _____ Pharm Phone: _____
Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:
- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Preferred Language: _____ ☐ Decline Response
Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____
Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

Patient Name (Print): _____
Patient Signature: _____ Date: _____
If completed by a patient's personal representative, please print and sign below.
Representative (Print): _____ Relationship: _____
Representative Signature: _____ Date: _____

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myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

☐ Send me an invitation to join myColumbiaDoctors.
Look for an email invite from noreply@followmyhealth.org and click the Registration link.

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Reason for today's visit: _____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	☐ Y ☐ N	Heart Disease/Disorder	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Lung Disorder	☐ Y ☐ N
Bleeding/Clotting Disorder	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
Blood Pressure Disorder	☐ Y ☐ N	Neurological Disorder/Chronic Headaches	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Psychiatric Disorder/Illness	☐ Y ☐ N
Bowel/Stomach Problems	☐ Y ☐ N	Pulmonary Embolism/DVT	☐ Y ☐ N
Cancer	☐ Y ☐ N	Stroke	☐ Y ☐ N
Cholesterol Disorder	☐ Y ☐ N	Seizure or Epilepsy	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Thyroid Disorder	☐ Y ☐ N
Eye Disorder (i.e. Glaucoma, cataract)	☐ Y ☐ N	Urinary/Kidney Disorder	☐ Y ☐ N

Please list any other medical illnesses or problems and provide details for any of the above conditions.

_____

_____

Please list any surgeries you have had and the approximate date.

Procedure	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	

Do you currently smoke? ☐ Y ☐ N If no, previously? ☐ Y ☐ N Years smoked _____ Packs/day _____

Do you use other tobacco products? ☐ Y ☐ N Consume alcohol? ☐ Y ☐ N If yes, drinks/week: _____

Do you have any allergies to medications or other substances? ☐ Y ☐ N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis).

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Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Provider Signature: _____ Date: _____

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Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

General	☐ None	☐ Fever	☐ Chills	☐ Feeling Poorly
	☐ Feeling Tired	☐ Weight Gain	☐ Weight Loss	
Eyes	☐ None	☐ Eye Pain	☐ Vision Changes	☐ Eyesight Problems
	☐ Dry Eyes	☐ Itchy Eyes		
Ear/Nose/Throat	☐ None	☐ Earache	☐ Loss of hearing	☐ Nose bleeds
	☐ Sinus problems	☐ Sore throat	☐ Hoarseness	
Heart	☐ None	☐ Chest pain	☐ Palpitations	☐ Fast heart rate
	☐ Slow heart rate	☐ Leg swelling	☐ Leg pain, discomfort, fatigue during walking	
Lungs/Breathing	☐ None	☐ Cough	☐ Wheezing	☐ Shortness of breath
	☐ Trouble breathing with exertion		☐ Trouble breathing when lying flat	
GastroIntestinal	☐ None	☐ Abdominal pain	☐ Constipation	☐ Diarrhea
	☐ Heartburn	☐ Nausea	☐ Vomiting	☐ Blood in stool
Bladder	☐ None	☐ Incontinence	☐ Discolored urine	☐ Painful urination
	☐ Pelvic pain	☐ Painful period	☐ Vaginal Discharge	
Skin	☐ None	☐ Acne	☐ Itching	☐ Change in a mole
	☐ Skin lesions	☐ Skin wound	☐ Breast pain	☐ Breast lump
Neurological	☐ None	☐ Confused	☐ Convulsions	☐ Dizziness
	☐ Limb weakness	☐ Loss of memory	☐ Headaches	☐ Difficulty walking
Psychiatric	☐ None	☐ Anxiety	☐ Depression	☐ Change in personality
	☐ Suicidal	☐ Disturbed sleep	☐ Emotional problems	
Endocrine	☐ None	☐ Weak muscles	☐ Feeling weak	☐ Deepening of voice
	☐ Hair loss	☐ Hot flashes		
Hem/Lymph	☐ None	☐ Easy bleeding	☐ Easy bruising	☐ Swollen glands

NewYork-Presbyterian

50705

PRE-PROCEDURE SCREENING TOOL

Please print clearly

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Name:_____ MRN:_____

Date of Birth:_____/_____/_____ Age:_____ Gender (circle one): M / F

Your E-mail:_____ Preferred Phone: ( ) _____ - _____

Best time to call:_____ May we leave a message (circle one)? Yes / No

Preferred language:_____ Do you need a translator on the day of surgery (circle one)? Yes / No

Do you have sight and/or hearing impairment (circle one)? Neither / Sight / Hearing / Both

Surgeon (full name):_____ Expected Date of Surgery: _____/_____/_____

Expected procedure: _____

Primary Care Physician (full name):_____ Phone: ( ) _____ - _____

Cardiologist (full name):_____ Phone: ( ) _____ - _____

Height (in feet and inches):_____ Weight (in lbs.):_____

Please list all current medical conditions:

Please list all allergies (medication, food) and reaction:

Please list all medications you are currently taking (including herbal supplements) and dose:

Please list all prior surgeries and dates:

Please check the boxes below to indicate if you have experienced any of the following problems with prior surgery or anesthesia (you may select more than one):

☐ Severe nausea/vomiting ☐ Problems placing breathing tube ☐ Nerve injury ☐ Slow wake up after anesthesia

☐ Personal/Family history of Malignant Hyperthermia ☐ Other:_____

Do you... ?	How much/often?	How many years?	If applicable, date quit?
Smoke cigarettes?			
Drink alcohol?			
Use recreational drugs?			

☐ I'd prefer to answer in person

IMPLANTS (please bring your wallet card on the day of surgery):

Do you have a pacemaker or an internal defibrillator (circle one)? Yes / No Brand?_____ Last check-up?_____/_____/_____

Do you have an artificial heart valve (circle one)? Yes / No ☐ Biologic valve ☐ Mechanical Valve

Do you have any implantable devices (check all that apply): ☐ PICC ☐ Broviac ☐ Dialysis catheter ☐ Fistula ☐ Ventricular device

☐ Insulin pump ☐ Other:_____

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PRE-PROCEDURE SCREENING TOOL

Please print clearly

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Please answer the following questions by putting a check mark in the appropriate box (Yes or No):

	Yes	No
Have you ever had a heart attack or cardiac bypass operation?		
Do you have stents in any artery in your brain or body?		
If yes, please ask your surgeon to complete the *Stent Letter*		
Do you have high blood pressure?		
Have you been diagnosed with congestive heart failure?		
Do you have atrial fibrillation or atrial flutter?		
Can you walk 2 city blocks or up 1 flight of stairs without stopping due to shortness of breath or chest pain?		
Do you have COPD or Asthma?		
Do you use a rescue inhaler (Albuterol) more than twice a week?		
Hospitalized for COPD/Asthma attack?		
Do you use supplemental oxygen at home?		
Have you been diagnosed or suspected to have Obstructive Sleep Apnea (OSA)?		
Do you use a BiPAP or CPAP machine at home?		
Do you have trouble lying flat on your back?		
If yes: ☐ because of pain ☐ because of breathing difficulty		
Do you have abnormal kidney function?		
Are you on Dialysis?		
Do you have Diabetes?		
Do you take insulin?		
Do you have? ☐ HIV? ☐ Hepatitis A? ☐ Hepatitis B? ☐ Hepatitis C?		
Have you been diagnosed with cirrhosis?		
Have you ever had a seizure?		
Have you ever had a stroke or surgery on your carotid arteries?		
Do you have any chronic pain that requires daily medication?		
Have you had chemotherapy for cancer?		
Have you ever had radiation to your neck or throat?		
Have you ever had a tracheostomy (an incision in windpipe for breathing)?		
Do you have trouble opening your mouth or looking up at the ceiling?		
Have you traveled outside of the US in the last two months? Where?_____		
Have you ever had a blood transfusion?		
Would you accept a blood transfusion if necessary?		
Have you been diagnosed with a bleeding disorder?		
Do you have problems with excessive bleeding after surgical or dental procedures?		
If you are a woman of childbearing age, are you or do you believe you may be pregnant?		

- If 1 or more of the bold boxes are checked AND the patient is undergoing high or intermediate risk surgery, it is recommended that the patient has a baseline EKG.
- If 2 or more of the bold boxes are checked, the patient should also be referred to their PMD/Cardiologist or the Anesthesiologist in Pre-Admission Testing.

Patient/Representative Signature:_____ Date:_____ /_____ /_____ Time:_____AM/PM