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