NBMC
NORTH BEND MEDICAL CENTER

NEW PATIENT INTAKE FORM

YOUR INFORMATION

Today's Date:

Name: DOB: Age: Gender:

Home Phone: ( ) Cell Phone: ( ) Please contact by: ☐ Home ☐ Cell

Address: City: State: Zip:

Pharmacy Name: City:

Insurance: Previous Provider (Doctor):

MEDICAL HISTORY (Check all that apply)

CONDITION	YOU	FATHER	MOTHER	SIBLING	OTHER w/ Relation
Anxiety	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes - Type 1	☐	☐	☐	☐	☐
Diabetes - Type 2	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	☐

CONDITION	YOU	FATHER	MOTHER	SIBLING	OTHER w/ Relation
Hepatitis	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Urinary Problems	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Prostate Problems	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
Other:					

MEDICATIONS (May provide list or bring in bottles)

MEDICATION NAME	DOSE	FREQUENCY

ALLERGIES

DRUG ALLERGY	REACTION	NON-DRUG ALLERGY	REACTION

SURGICAL HISTORY

PROCEDURE	APPROXIMATE DATE

TESTS (List approximate date)

MAMMOGRAM	PROSTATE EXAM
PAP SMEAR	STRESS TEST
BONE DENSITY	HEARING TEST
COLONOSCOPY	FOOT EXAM
EYE EXAM	EKG

VACCINES (List approximate date)

PNEUMONIA
SHINGLES
TETANUS
FLU

LIST ALL OTHER DOCTORS/SPECIALISTS/PROVIDERS WHO PARTICIPATE IN YOUR CARE

PROVIDER TYPE	PROVIDER NAME	PROVIDER TYPE	PROVIDER NAME
PRIMARY CARE PROVIDER		ORTHOPEDIC DOCTOR (BONE/MUSCLE)	
CARDIOLOGIST (HEART)		OTOLARYNGOLOGIST (EAR/NOSE/THROAT)	
DERMATOLOGIST (SKIN)		PAIN MANAGEMENT	
ENDOCRINOLOGIST (HORMONE)		PHYSICAL THERAPY	
GASTROENTEROLOGIST (STOMACH)		PSYCHIATRIST OR COUNSELOR	
PULMONOLOGIST (LUNG)		RHEUMATOLOGIST (AUTOIMMUNE)	
NEPHROLOGIST (KIDNEY)		SOCIAL WORKER/CASE WORKER	
NEUROLOGIST (NERVOUS SYSTEM)		UROLOGIST (KIDNEY/BLADDER)	
OB/GYN (WOMEN'S HEALTH)		OTHER:	
ONCOLOGIST/HEMATOLOGIST (CANCER)		OTHER:	

SOCIAL HISTORY

☐ **TOBACCO**	PACKS PER DAY:	HOW MANY YEARS?:	WHEN DID YOU QUIT?:	
☐ **SMOKELESS**	USES PER DAY:	HOW MANY YEARS?:	WHEN DID YOU QUIT?:	
☐ **ALCOHOL**	DRINKS PER WEEK:	TREATMENT?:	WHEN DID YOU QUIT?:	
☐ **DRUGS**	TYPE:	TREATMENT?:	WHEN DID YOU QUIT?:	
☐ **MEDICAL MARIJUANA**	REASON:		HOW LONG?:	
☐ **EXERCISE**	TYPE:	MINUTES PER DAY:	DAYS PER WEEK:	

OCCUPATION: ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ DISABLED

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED