NEW PATIENT INFORMATION / Medical History

Name: _____ DOB: _____

Please list what you would like to discuss today at your appointment:

1) _____

2) _____

PHARMACY:

Local: _____ Mail Order: _____

Phone Number(s): _____

ALLERGIES:

Allergies to medications with REACTION/S: _____

_____

Allergies to food / environment / other with REACTION/S:

_____

_____

MEDICATION LIST:

List ALL medications you take, including over-the-counter (OTC) medications and vitamins. Include name of medication, strength, and dosage.

Name	**Strength**	**Dose**

Name:_____ DOB: _____

Personal Medical History: Please circle all that apply

ADHD	COPD/Emphysema	Kidney Disease	Rheumatoid Arthritis
Alcoholism	Dementia	High Cholesterol	Seizures
Allergies, Seasonal	Depression	HIV	Sleep Apnea
Anemia	Diabetes 1 or 2	Hepatitis	Stroke
Anxiety	Diverticulitis	Irritable Bowel Syndrome	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (blood clot)	Lupus	Ulcerative Colitis
Arthritis	GERD (acid reflux)	Liver Disease	
Asthma	Glaucoma	Macular Degeneration	
Bipolar	Heart Disease	Neuropathy	
Bladder Problems/ Incontinence	Heart Attack	Osteopenia/Osteoporosis	
Bleeding Problems	Hiatal hernia	Parkinson's disease	
Cancer:_____	High Blood pressure	Peripheral Vascular Disease	
Crohns Disease	Kidney Stones	Pulmonary Embolism (PE)	

Surgical History: Please list all prior surgeries and approximate dates performed.

Name of Surgery Date

_____

_____

_____

_____

_____

Name: _____ Date: _____

Social History:

Smoking/tobacco use: Never____ Current ____ Past ____ Type:_____
Amount per Day: _____ # of Years: _____

Alcohol: Current _____ Past_____ Never _____ Drinks/week: _____

Substance Abuse: Current _____ Past _____ Never _____ Type: _____

Occupation: _____

Home/Environment:
Where do you currently reside (home/apartment/residential facility): _____
Who lives with you (significant other, spouse, child/grandchild)? _____
Any pets: _____

Diet: Regular ___, Restricted ___, Diabetic ___, Renal ___, Vegetarian ___, Other _____
Do you drink: Coffee ____ Soda ___ Tea ____ How much per day? _____

Exercise: Duration _____ Times per week _____ Type of exercise: _____

Sleep Pattern: Changes _____ No changes _____ How many hours do you sleep each night? _____

General Social/Cultural History:
Education level: ___ Elementary ___ High School ___ Vocational ___ College ___ Graduate/Professional
Are there any vision problems that affect our communication? Yes/No
Are there any hearing problems that affect your communication? Yes/No
Are there any limitations to understanding or following instructions (written or verbal)? Yes/No
Are there any cultural or religious concerns you have related to our delivery of care? Yes/No
Are there any financial issues that directly impact our ability to manage your health? Yes/No

Advanced Directives:
___ None ___ DNR ___ Durable Power of Attorney ___ Living Will ___ HC Proxy

Name: _____ Date: _____

Family History:

Diagnosis	Mother	Father	Brother	Sister	Grandmother Maternal	Grandfather Maternal	Grandmother Paternal	Grandfather Paternal
Asthma								
Cancer								
Depression								
Diabetes								
Heart Disease								
High Cholesterol								
Hypertension								
Mental Illness								
Thyroid Disorder								
Stroke								
Other								

<u>Outside Providers</u>:

Name	Specialty	Phone Number

JMH Podiatry
1159 W. Jefferson Street, Suite 204
Franklin, IN 46131
Phone 317-346-3913
Fax 317-346-3001

Our goal is to ensure that your experience at Johnson Memorial Health is exceptional. To ensure the highest quality service and care for our patients, we have policies and procedures we ask you to observe. If you have any questions or concerns, please contact our office.

Patient Information: A patient registration and medical history form is enclosed, please complete them prior to your upcoming visit and bring them with you to your appointment.

Insurance cards: Please bring a copy of your insurance card with you to every appointment. Without it there is no way to submit your insurance and it will be assumed you are self-pay.

Photo ID: In order to protect your identity, please bring a Photo ID with you to every visit. If you cannot provide this, we may need to reschedule your appointment.

Late arrival: Please be prompt when arriving for you appointment; we ask that you arrive 15 minutes early so we do not take away from your time with the provider.

No Show: If you are unable to keep your appointment, please give 24-hour notice. If there are excessive no shows, be advised that is grounds for dismissal from the practice.

Co-Pay: Your co-pay is required at the time of service per your insurance provider.

Medical Records: Upon written request and signature, a copy of your medical records will be released to you. This process can take 7-10 business days. The state of Indiana has imposed a predefined fee schedule for copying medical records that will be charged accordingly to the patient.

We look forward to meeting you and establishing a relationship to meet your healthcare needs!