Coquille Valley Hospital

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) & (Name of facility/provider)

VACCINES

Date	Facility/Provider	Date	Facility/Provider	List approximate date
Mammogram		Prostate Exam		Pneumonia
Pap Smear		Stress Test		Shingles
Bone Density		Hearing Test		Tetanus
Colonoscopy		Foot Exam		Flu
Eye Exam		EKG		

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