LAKESHORE FAMILY MEDICINE NEW PATIENT HEALTH INFORMATION SHEET

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Name:
Date of Birth:
Address:
Phone where you can be reached during the day:

Emergency Contact:_____

MEDICATIONS:

NAME OF MEDICATION	DOSE

HISTORY OF SURGERIES: PLEASE INCLUDE COLONOSCOPIES

SURGERY	DATE AND PLACE

MEDICAL CONDITIONS: CHECK EACH THAT APPLY

- O DIABETES
- \bigcirc HEART DISEASE
- ◯ HIGH BLOOD PRESSURE
- ◯ SHORTNESS OF BREATH
- ◯ CHRONIC PAIN

- VASCULAR DISEASE
- HIGH CHOLESTROL
- \bigcirc TROUBLE URINATING
- \bigcirc ANXIETY
- TROUBLE WALKING

SPECIALTY PHYSICIAN: WHO DO YOU SEE OTHER THAN PRIMARY CARE?

CHECK EACH THAT APPLY

NAME OF DOCTOR

- O PULMONOLOGY
- ◯ GI SPECIALIST
- ◯ PAIN MANAGEMENT

- ◯ SUBSTANCE COUNSELING
- \bigcirc VASCULAR
- MENTAL HEALTH COUNSELING

SPECIAL CONCERNS TO BE ADDRESSED: