NEW PATIENT PACKET

Demographics

Please verify and update the below demographic information for the patient.

First Name:	Middle Name	Last name	Suffix
Nickname:			

Street Address:_____
Apartment/Suite#_____
Email Address:_____
Cell Phone number: _____
Work Phone:_____
Landline:_____

Birthdate:_____
Gender:

- Female
- Male
- Other

Ethnicity:

- Decline to specify
- Hispanic or Latino
- Not Hispanic or Latino

Marital Status:

- Divorced
- Legally Separated
- Married
- Single
- Unknown
- Widowed

Employment Status:

- Employed full time
- Employed part time
- Not employed
- On Active military duty
- Retired
- Self employed
- Unknown

Employer Name: _____

Student Status:

- Full time student
- Not a student
- Part time student

Current Primary Care provider name and address (if not established with us):

_____

Responsible Party:
Please verify and update the below responsible party information. The responsible party is the person who is financially responsible for payments after insurance.

- The patient
- Another individual
- A company
- Does not apply

Emergency Contact:

Name and Phone number:

_____

Relationship to patient: _____

Would you like this person to access your health information? Yes No
Would you like this person to be able to pick up medications? Yes No

Appointment Reminders:

- Phone call (please write number): _____
- Text Message (please write number): _____
- Email (provide email address): _____

Allergies:

Please list all allergies:

- I currently do not have any allergies

Medications:

Please list all medications and dosages that you are currently taking, including over the counter medications.

- I currently do not take any medications

Insurance Information: (Reminder: If you have an HMO policy, that is not open access, please call your insurance company prior to your appointment and change your card to reflect Derek McCoy, MD despite who you are seeing in our practice)

Insurance Provider: _____
Member ID: _____
Group Number: _____

Patient History:

1. If you allergic to any of the following, please circle:

Adhesive tape	Metal
Iodine	Seafood
Latex	Contrast Dye
Dust	Food
Mold	Pollen

2. Please circle if you have been diagnosed with any of the following:

Adenoid enlargement	Glaucoma	Other Cancers:
ADHD (inattentive/hyperactive)	Hearing loss - aging	Perforated eardrum
ADHD - predominantly hyperactive	Hearing loss – infections	Pregnant
ADHD – predominantly inattentive	Hearing loss – noise damage	Prostate Cancer
AIDS/ Related Complex	Heart Arrythmia	Prostate Enlargement
Alcoholism	Hemophilia	Recurrent Tonsillitis
Anemia	Hepatitis A	Reflux
Anxiety	Hepatitis B	Renal Failure
Asthma	Hepatitis C	Rheumatoid arthritis
Autoimmune disorder	Hiatal hernia	Sinusitis

Blood clots/DVT	High Blood pressure	Skin cancer
Breast cancer	HIV	Sleep apnea
Cataracts	HIV positive	Sleep disorder
Chronic tonsillitis	Hypertension	Stomach ulcer
BPH	Hyperthyroidism (overactive)	Stroke
Depression	Hypothyroid (underactive thyroid)	Throat Cancer
Deviated nasal septum	Kidney disease	Thyroid Disorder
Diabetes	Leukemia	Thyroid Nodule
Eczema	Lung cancer	TMJ
Emphysema	Migraines	Tonsil enlargement
GERD	Nasal Allergies	Tuberculosis
Chronic bronchitis	Osteoarthritis	Wax buildup

3. Circle the history of family members who have been diagnosed with any of the following:

Mother

Asthma	Bleeding/Clotting problems	Diabetes
Hearing loss after age 20	Hearing loss before age 20	Heart disease
High Blood Pressure	Lung Cancer	Problems with Anesthesia
Stroke	Thyroid Cancer	Unspecified cancer

Father

Asthma	Bleeding/Clotting problems	Diabetes
Hearing loss after age 20	Hearing loss before age 20	Heart disease
High Blood Pressure	Lung Cancer	Problems with Anesthesia
Stroke	Thyroid Cancer	Unspecified cancer

Brother

Asthma	Bleeding/Clotting problems	Diabetes
Hearing loss after age 20	Hearing loss before age 20	Heart disease
High Blood Pressure	Lung Cancer	Problems with Anesthesia
Stroke	Thyroid Cancer	Unspecified cancer

Sister

Asthma	Bleeding/Clotting problems	Diabetes
Hearing loss after age 20	Hearing loss before age 20	Heart disease
High Blood Pressure	Lung Cancer	Problems with Anesthesia
Stroke	Thyroid Cancer	Unspecified cancer

4. Patient birth history (18 years and younger) Circle all that apply:

Maternal history of rubella in 1st trimester	Complicated delivery
Placed in NICU (neonatal intensive care unit)	Patient was intubated
Transfusion given	Jaundice
Delayed growth and development	Premature birth
Down syndrome	List birth weight if under 5lbs:

5. Are you retired? _____

6. List any surgeries you have had:

7. Tobacco Use: (circle all that apply)
- o Cigarettes
- o Smokeless Tobacco
- o Cigars
- o Vaping

If applicable, how many cigarettes do you smoke in an average day and at what age did you start smoking?_____

Number of alcoholic beverages per week: _____

8. Are your immunizations up to date? _____

9. Do you use drugs recreationally? If so, which ones?_____

10. Amplification:
    - Hearing Aids
    - FM system/assistive listening devices

11. Are you exposed to second hand smoke? Yes or no

12. Does the patient attend daycare? Yes or no

13. Will you accept transfusion of blood products if necessary? Yes or no

14. Home living situation: Circle all that apply

Alone	With Children	With Mother	Assisted Living
With Spouse	Nursing Home	With Father	Other:

Please list the pharmacy and their address where you would like your medications sent:

Review of Systems – Circle all that apply

Change in sense of smell	Night sweats	Chest pain	Night time awakening
Change in thirst	Neck has enlarged	Cold feeling	Numbness
Chills	Pain in neck	Difficulty swallowing fluids	Pain or burning with urination
Diarrhea	Painful eye	Dizziness	Painful joints
Difficulty swallowing solids	Painful swallowing	Drooping on one side of face	Partials or dentures
Double vision	Post- nasal drainage	Ear infection	Runny nose
Ear drainage	Restless sleep	Easily bruise	Ringing in the ears
Ear pain	Seizures	Fatigue	Sensation of a lump in throat
Excessive daytime sleepiness	Sensitivity to light	Frequent congestion	Severe face pain
Fever	Shortness of breath	Frequent nosebleeds	Sleeping problems
Frequent non-productive cough	Sneezing	Head noise	Snoring (excessive)
Headache	Spinning Sensation	Hearing loss	Stiffness in joints
Heart murmur	Swelling of ankles	Heartburn	Swelling of joints
Hives	Tremor	Hoarseness in voice	Trouble swallowing
Inhaling food or drink	Unintentional weight gain	Irregular heartbeats	Unintentional weight loss
Itchy eats	Vomiting	Itchy eyes	Wheezing
Itchy nose	Appetite is increased	Leg cramps	Sore throat
Lightheadedness	Bedwetting	Loss of vision	
Lumps in armpit	Blacking out or fainting	Lumps in groin	
Lumps in neck	Blurred vision	Mouth bleeding	
Mouth ulcers	Bruise easily	Nasal congestion	
Nausea	Change in sense of taste	Nasal obstruction	