Nabors Family Medicine

NEW PATIENT FORMS

Thank you for establishing care with our office. Please answser the questions below to the best of your ability. While many questions assist us in addressing national health concerns, additional others help for a more indepth look at your health needs with a personalized approach. We look forward to working together to meet your needs of healthcare.

Patient Name: _____ Date of Birth: _____

Address _____
(Street) (City) (State) (Zip Code)

Email: _____ ❑ M ❑ F ❑ Other

❑ Cell
Phone: _____ ❑ Home Additional Phone: _____

Emergency Contact: _____ Relationship: _____

❑ Cell
Phone: _____ ❑ Home Email: _____

If patient is a minor:

Parent/Guardian Name: _____ Relationship: _____

❑ Cell
Phone: _____ ❑ Home Additional Phone: _____

Emergency Contact: Name: _____ Relationship _____
Phone: _____

INSURANCE

Primary Insurance: _____ Member Number: _____

Name of Person on Card: _____ Group Number: _____

DOB: _____ Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Dependent

Secondary Insurance: _____ Member Number: _____

Name of Person on Card: _____ Group Number: _____

DOB: _____ Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Dependent

SOCIAL HISTORY

❑ Married ❑ Single ❑ Divorced ❑ Widow

Alcohol: ❑ Yes ❑ No Amount: _____ Tobacco use: ❑ Yes ❑ No Amount: _____

Smokeless Tobacco: ❑ Yes ❑ No Amount: _____ Vaping ❑ Yes ❑ No

Any history of substance abuse (including pain meds) ❑ Yes ❑ No If Yes, What: _____

FAMILY HISTORY: *(Mother, Father or Siblings) (e.g. heart disease, diabetes, cancer etc.):*

❑ Allergies
❑ Alcoholism/Drug
❑ Anxiety
❑ Asthma
❑ Breast Cancer
❑ Bleeding Disorder
❑ Cancer
❑ Depression
❑ Diabetes
❑ Heart Disease
❑ Heart Attack
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disorder
❑ Liver Disease
❑ Lung Cancer
❑ Migraine
❑ Osteoporosis
❑ Ovarian Cancer
❑ Prostate Cancer
❑ Seizures
❑ Stroke
❑ Thyroid Disorder
❑ Other:

HEALTH MAINTENANCE

Zoster (Shingles) Vaccine: Date: _ Tetanus: Date: _____

Do you wear glasses or contacts? □ Yes □ No

When was your last eye exam? Date: ___/___/____ □Never □Unknown

When was your last dental exam? Date: ___/___/____ □Never □Unknown

When was your last DEXA scan Date: ___/___/____ □Never □Unknown ❑ Abn ❑ Norm

When was your last Tetanus shot? Date: ___/___/____ □Never □Unknown

When was your last Pneumonia shot? Date: ___/___/____ □Never □Unknown

When was your last Flu Vaccine? Date: ___/___/____ □Never □Unknown

Have you received Covid 19 Vaccines: ❑ Yes ❑ N ❑ Declined

Colonoscopy: Date: _____ Finding: _____ Repeat: _____ years

WOMEN: Mammogram: Date: _____ LMP: _____ Last Pap Smear: _____ ❑ Abn ❑ Norm

# of Pregnancies: Full Term Births:_____ Miscarriages:

MEN: Last Prostate Exam: _____ Findings: _____

BEHAVIOR AND CONTRACEPTION USE

Are you sexually active? □ Yes □ No If YES please select all that apply:

□ Single Male Partner □ Multiple Male Partners □ Single Female Partner

□ Multiple Female Partners □ Safe Sex

Birth Control: ❑ Depo Provera ❑ Diaphragm ❑ Intrauterine Device ❑ Patch

❑ Pills ❑ Tubal Ligation ❑ Vasectomy ❑ Vaginal Ring ❑ Inplantable

❑ Condom ❑ Abstinence ❑ None ❑ Hysterectomy Year: _____

CURRENT MEDICATIONS (*including, over the counter medications and vitamins*)

Name	Dose	Directions for use	Need Refills?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

Pharmacy: _____

ALLERGIES: (*Please include FOODS and MEDICATIONS*) and the reaction.

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL MEDICAL HISTORY

- ❑ Anemia
- ❑ Acid Reflux
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding problems
- ❑ Cancer
- ❑ Chronic Back Pain
- ❑ Eczema
- ❑ Epilepsy / Seizures
- ❑ Other:
- ❑ Fractures / Dislocations
- ❑ Heart Problems
- ❑ Hepatitis type
- ❑ High Blood Pressure
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Problems
- ❑ Lung Problems
- ❑ Migraines
- ❑ Pneumonia
- ❑ Psychiatric Care
- ❑ Renal Dsease
- ❑ Seasonal Allergies
- ❑ Skin Conditions
- ❑ Sleep Problems
- ❑ Sexually transmitted disease
- ❑ Strokes
- ❑ Thyroid disease
- ❑ Transfusions

If you checked any of the boxes from the problem list above, please explain: _____

_____

_____

SURGICAL HISTORY: (*Include major hospitalizations and operations, with dates*)

_____ _____

_____ _____

_____ _____

_____ _____

HEALTHCARE TEAM

Please list members of your current care team (health care providers and / or clinics

Eye Care Provider: _____ Date of Last Exam: ____/____/____

Dental Provider: _____ Date of Last Exam: ____/____/____

Other: _____ Specialty: _____

Other: _____ Specialty: _____

MENTAL HEALTH

Please answer the following questions for review of mental health over the last 2 weeks.

Depression Screening: Over the past 2 weeks, have you felt down, depressed or hopeless? □ Yes □ No

Over the past 2 weeks, have you felt little interest or pleasure in doing things? □ Yes □ No

ADVANCED DIRECTIVES

Do you have a living will or advance directive? ❑ Yes ❑ No

Do you have a copy to place in your chart? ❑ Yes ❑ No

Patient Signature: _____ Date: _____