**Pure Internal Medicine** **New Patient Form**

**Office of Dr. Shyam Mahesh Date: \_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_**

**Last Name First Name**

**Birth Sex:**  **Male**  **Female**  **Undifferentiated**

**Current Gender Identity:**  **Male**  **Female**  **Choose not to disclose**

**Female to Male/Transgender Male**  **Genderqueer**

**Male to Female/Transgender Female**

**Preferred Pronoun:**  **Decline to answer**  **He, Him, His**

**She, Her, Hers**  **They, Them, Theirs**  **Ze, Hir**  **Other**

**Marital Status:**  **Single**  **Married**  **Widow (er)**  **Partner**

**Divorced**

**Who do you live with?**  **Alone**  **Partner**  **Family**  **Other**

**Ethnicity:**  **Alaskan Native or American Indian**  **African American**

**Hispanic or Latino**  **Native Hawaiian or Pacific Islander**

**White**  **Unknown**  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Declined**

**Primary Language**  **English**  **Spanish**  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Declined**

**Address City State Zip Code**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone Email**

**Would you like to enroll in the Patient Portal?**  **Yes**  **No**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name Emergency Contact Phone Number**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name City Telephone Number**

**Insurance Policy Name Holder Insurance Policy Number**

**Medications**

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**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Past Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Social History:**

**Alcohol Use**  **Yes**  **No**  **Former**

**If Answered Yes, please Answer the following:**

**Years Drinking \_\_\_\_\_\_\_ How Much Per Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tobacco Use**  **Yes**  **No**  **Former**

**Cigarettes Packs per day & how many years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cigars Cigars per day & how many years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Smokeless tobacco/Vape How many years using \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chewing tobacco How many years using\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Caffeine**  **Yes**  **No If answered yes how much per week**

**Coffee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Pop/Soda \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Energy Drinks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recreational Drug Use**  **Yes**  **No**  **Former**

**Have you ever used IV drugs?**  **Yes**  **No**

**Sexual History**

**Are you currently sexually active?**  **Yes**  **No**

**Any history of sexually transmitted diseases?**  **Yes**  **No**

**Personal Safety**

**Do you wear your seatbelts when driving?**  **Yes**  **No**

**Do you have difficulty dressing yourself?**  **Yes**  **No**

**Do you have difficulty carrying 10 pounds?**  **Yes**  **No**

**Do you have difficulty shopping?**  **Yes**  **No**

**Have you had any falls you in the last year?**  **Yes**  **No**

**If yes, how many falls in the past year? \_\_\_\_\_\_\_\_\_**

**Were you injured in the fall?**  **Yes**  **No**

**Exercise**  **Yes**  **No**

**How hours per week of exercise? \_\_\_\_\_\_\_\_**

**Mood**

**Little interest in doing things**  **Not at all**  **Several days**

**More than half the days**  **Nearly daily**

**Feeling down, depressed or hopeless**  **Not at all**

**Several days**  **More than half the days**

**Nearly daily**

**Do you work?**  **Yes**  **No**  **Retired**

**Do you have a Living Will/Durable Power of Attorney?**  **Yes**  **No**

**How many children do you have? \_\_\_\_\_\_\_\_\_**

**Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Vaccination History:**  **Hepatitis A**  **Hepatitis B**  **HPV**

**Influenza**  **Tetanus vaccination**  **Pneumovax**  **Prevnar 13**

**Shingles vaccines**  **Covid Vaccine**  **Covid booster**

**FOR WOMEN ONLY**

**How many pregnancies? \_\_\_\_\_\_\_\_ How many live births? \_\_\_\_\_\_\_\_**

**Menstrual History:**

**First day of last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use any form of birth control?**  **Yes**  **No**

**If yes, which form of birth control? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Screening Tests**

**Date of last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any abnormal PAP Smears?**  **Yes**  **No**

**If yes, what are the results and the date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mammogram:**

**Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was the mammogram abnormal?**  **Yes**  **No**

**If yes, what are the rests and the date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature Date**

**Pure Internal Medicine**

**Dr. Mahesh**

**Additional Information**

**Please bring your insurance card and driver’s license** **to all your appointments**

**We are happy to refill medications as long as you have been seen by Dr. Mahesh within the past 4 months**

**Please notify our office a week in advance prior to a medication refill request as opposed to reaching out to your pharmacy**

**Please provide a 24 hour notice in order to avoid $25 fee for late cancellation**

**If FMLA forms or medical forms need to be completed by Dr. Mahesh it is a $25**

**Copying Medical charts is $25**

**Labs can be drawn in the office during the office visit or prior to the office visit**

**If you need a prior authorization for diagnostic test, a physician referral or a medication please notify us, and allow us 48 hours to complete your request**

**Signature Date**