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

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

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

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

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

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

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

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

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

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**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**