



# St. Elizabeth's Hospital Medical Building

## New Adult Patient History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Last) (First) (M.I.) mo. day yr.

### Work/School

Present occupation: \_\_\_\_\_ Do you work shift work? \_\_\_\_\_

Other types of work done: \_\_\_\_\_

Are you retired?  No.  Yes, in \_\_\_\_\_ (year).

Are you a student?  No.  Yes, in this area of study: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_

### Personal Habits

Do you use tobacco?  No.  Yes: what form(s)? \_\_\_\_\_

-- how much? \_\_\_\_\_  per day  per week

-- when did you start? \_\_\_\_\_

Do you use drink alcohol?  No.  Yes: what kind(s)? \_\_\_\_\_

-- how often?  daily  weekly  special events \_\_\_\_\_

-- how much? \_\_\_\_\_

Do you drink beverages containing caffeine?  No.  Yes: how much? \_\_\_\_\_

Do you get regular exercise?  No.  Yes: what kind? \_\_\_\_\_

Have you had any major stressful events (like divorce, move, new baby, or job change) in the last year or so?

No.  Yes. Please list: \_\_\_\_\_

### Family Situation

Please list the members of your household and your relationship to them: \_\_\_\_\_

\_\_\_\_\_

What is your marital status? \_\_\_\_\_

### Allergies

Are you allergic to any drugs, foods, or other substances?  No.  Yes. Please list:

Date	Medicine/Food/Other	Kind of Reaction

### Vision/Hearing

Do you wear glasses or contact lenses?  No.  Yes. \_\_\_\_\_

Are you hard of hearing?  No.  Yes. \_\_\_\_\_

## Medications

Are you currently taking medications? [ ] No. [ ] Yes. Please list:

Name of Medication	Dosage

Name of Medication	Dosage

## Medical History

Have you ever had:

	No	Yes
High Blood Pressure?		
Heart Problems?		
Lung Problems (Asthma, Bronchitis)?		
Stroke?		
Kidney/Bladder Trouble?		
OTHER:		

	No	Yes
Diabetes/High Blood Sugar?		
Seizures/Epilepsy?		
Cancer?		
Broken Bones?		
Arthritis?		
OTHER:		

When was your last tetanus shot? \_\_\_\_\_

## Hospital Stays

Please list all your hospitalizations for surgery, illness, or childbirth:

Year	Reason You Were in Hospital	Name of Hospital

## Family History

Has any member of your family had:

	No	Yes	Which Relative?
High Blood Pressure?			
Diabetes?			
Heart Problems?			
Lung Problems?			
Stroke?			
Kidney Disease?			
Cancer (what kind)?			
Seizures/Epilepsy			
Inherited Diseases (like sickle cell, Huntington's)?			
Alzheimer's Disease or severe memory problems?			
OTHER:			

Reviewed by \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## New Patient Information

Name \_\_\_\_\_  
(Last) (First) (M.I.)

Today's Date \_\_\_\_\_

Home Address \_\_\_\_\_  
(Street) (Apt/Lot)

(City) (State) (Zip Code)

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Birth \_\_\_\_\_  
(Month Day Year)

Sex:  Male  Female Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ How related to Patient \_\_\_\_\_ Phone(H) \_\_\_\_\_ Phone(W) \_\_\_\_\_

Acceptance  
Date: \_\_\_\_\_

Assigned Provider  
\_\_\_\_\_

Permanent  
 Community Coverage

## Policy Holder's Information

Name \_\_\_\_\_  
(Last) (First) (M.I.)

Office use

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_  
(Month Day Year)

Address (if different from patient) \_\_\_\_\_  
(Street) (Apt/Lot)

(City) (State) (Zip Code)

How related to patient: \_\_\_\_\_ Sex:  Male  Female Home Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(Street) (Suite) (City) (State) (Zip Code)

## Policy Holder's Information

Primary Insurance Insurance Plan \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

D.O.B. \_\_\_\_\_ Policy ID Number \_\_\_\_\_

Policy Holder's Soc. Sec. Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Other Family Members on Plan \_\_\_\_\_

(Name & Date of Birth)

Group Number: \_\_\_\_\_

(Name & Date of Birth)

Office use

Co-Payment?  No  Yes: \$ \_\_\_\_\_

Effective Date of Plan \_\_\_\_\_

(Name & Date of Birth)

(Name & Date of Birth)

Secondary Insurance Insurance Plan \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Policy ID Number \_\_\_\_\_

Policy Holder's Soc. Sec. Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Other Family Members on Plan \_\_\_\_\_

(Name & Date of Birth)

(Name & Date of Birth)

(Name & Date of Birth)

Co-Payment?  No  Yes: \$ \_\_\_\_\_

Effective Date of Plan \_\_\_\_\_

(Name & Date of Birth)

(Name & Date of Birth)

Kid Care ID Number \_\_\_\_\_

Effective Date \_\_\_\_\_

Medicare Medicare Number \_\_\_\_\_

Effective Date \_\_\_\_\_

Harmony Health Case Number \_\_\_\_\_  
Recipient ID Number \_\_\_\_\_

Case ID Number \_\_\_\_\_

Eligibility Period \_\_\_\_\_ through \_\_\_\_\_

Public Aid Case Number \_\_\_\_\_  
Recipient ID Number \_\_\_\_\_

Case ID Number \_\_\_\_\_

Eligibility Period \_\_\_\_\_ through \_\_\_\_\_

Method of Payment:  Cash  Check