reena r. patel md, inc

NEW PATIENT FORM

PATIENT DEMOGRAPHICS				DATE: _________________
Prefix:	Patient's First Name:	Preferred Name:	M.I.:	Last Name:

Mailing Address:	Apt:	City:	State:	Zip Code:

Marital Status:	Birth Date:	Age:	Sex At Birth:	Gender Identity:

Guardian's First and Last Name (if patient is a minor):	Relationship to Patient:

PLEASE MARK THE BOX OF YOUR PREFERRED PHONE CONTACT:

☐ Home Phone:	☐ Work Phone:	☐ Cell Phone:

Driver's License No. / State:	Email address:	Occupation:

Preferred Pharmacy.:	Pharmacy Phone No.:

ADDITIONAL DEMOGRAPHICS:

These questions are required to comply with the new Federal Health guidelines - every patient is asked this information.

Race/Ethnicity (please check one):

☐ American Indian/Alaskan Native ☐ Hispanic or Latino ☐ Black/African American

☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ South Asian ☐ Decline to specify

Preferred Language (Check One):

☐ English

☐ Spanish

☐ Other___________________

INSURANCE INFORMATION FOR LAB/IMAGING ORDERS & FOR MEDICARE BILLING

Primary Insurance Company: ______________________________ Effective Date: _________ Social Security No.:____________________________

Policy Holder Name:______________________________ Policy #:____________________________ Group #:______________________________

IN CASE OF EMERGENCY

First Name of Contact:	Last Name of Contact:	Relationsh to Patient:
☐ Home Phone:	☐ Work Phone:	☐ Cell Phone::

I ALLOW MY MEDICAL NFORMATION TO BE RELEASED TO:

First Name:	Last Name:	Relationship to Patient:

Name: ______________________________

MEDICAL HISTORY

Reason for today's visit: ____ Date: ________________

DRUG ALLERGIES:

ALLERGY	REACTION
____	____
____	____

MEDICATIONS:

Please list all prescription & over-the-counter medications, vitamins, herbals that you are taking:

1. __________________________ 2. ____________________________ 3. ______________________________

4. ___________________________ 5. ____________________________ 6. ______________________________

PRIOR OR CURRENT MEDICAL HISTORY:

___ANEMIA

___ARRHYTHMIA

___ARTHRITIS

___BLOOD DISORDER/BLOOD CLOTS

___CANCER (TYPE)______________________

___COPD

COVID_______________

___DIABETES

___DEPRESSION

___HEART ATTACK (DATE)_____________

___HIGH BLOOD PRESSURE

___HIGH CHOLESTEROL

___KIDNEY DISEASE

___MIGRAINES

___THYROID DISEASE

___STROKE (DATE)____________________

___OTHER:___________________________

PREVIOUS SURGERIES, SERIOUS ILLNESS, AND/OR HOSPITALIZATIONS:

CONDITION/EVENT	YEAR
____	______________________________
____	______________________________

1730 Huntington Dr., Ste #203, South Pasadena, CA 91030 P: 626-765-7852 F: 626-606-3952 E: office@ReenaMD.com Web: www.ReenaMD.com

Name: ______________________________ Date: _______________

FAMILY HISTORY: (Please indicate immediate family for all/any that apply)

Disease	Family Member	Age of Onset/Death
Asthma	______________	________________
Colon Cancer	______________	________________
Diabetes	______________	________________
Depression	______________	________________
Female Cancers	______________	________________
(☐ breast, ☐ ovarian, ☐ cervical, ☐ uterine)		
Heart Attack	______________	________________
High Blood Pressure	______________	________________
High Cholesterol	______________	________________
Thyroid disease	______________	________________
Prostate Cancer	______________	________________
Skin Cancer	______________	________________
Stroke	______________	________________
Other	______________	________________

HEALTH MAINTENANCE:

Date of Immunizations:

Covid vaccine (type & date(s)): ________________________

Flu shot: ________________ Tetanus: _________________

Pneumonia vaccine: ________________ Shingles vaccine: _________________

Date of: Last Physical ____________ Last of Blood Tests ____________ Colonoscopy____________

For Men: Last PSA (prostate test) ______________

For Women: Last Mammogram _________ Pap Smear _________ Bone Density ___________

SOCIAL HISTORY:

Occupation:______________________ Marital Status:_________________ #of children: boy _____ girl_____

ACTIVITY LEVEL:

Do you exercise regularly? ________ What type(s)? __________________How many times/week? _________

CAFFEINE:

Do you drink caffeine? _______ What type(s)? ________________________ How many cups/day? ___________

Name: ____________________________ Date: ______________

TOBACCO:

____Never smoked.

____I used to smoke ______ ☐ cigarettes/☐ packs (check one) per ☐ day/☐ week/☐ month (check one) for _______years, but I quit in ________.

____I currently smoke _____ ☐ cigarettes/☐ packs (check one) per ☐ day/☐ week/☐ month (check one) for _____years .

____****Please let us know if you are interested in quitting!**

ALCOHOL:

Do you currently drink alcohol? ___________ What type(s)? ____

I drink ___________ (number of drinks) every ____________________(☐ day/☐ week/☐ month)

Is your alcohol a concern for you or others? ____

DRUGS:

Do you use recreational drugs? ___________ What type(s)? _______________________________________

Have you ever used injected drugs? ______________________________

SEXUAL ACTIVITY:

Have you ever been sexually active? ___________ Currently sexually active? ____________________

Sexual preference (☐ male/☐ female/☐ both): _______________ Birth control method: ___________________

Have you ever had a sexually transmitted disease (STD)? ____

Are you interested in being screened for STDs?__________________.

GYN HISTORY:

Please indicate the number of pregnancies and deliveries below:

Pregnancies ____ Live Births ____ Vaginal Delivery ____ C-sections ____ Miscarriage ____ Abortions ____

Menarche (Age of first period)? ____________ Date of last menstrual period? _______________

Are your periods regular or irregular?_______________ Flow (light/moderate/heavy)________________

Menopause?________ What age?________________