Geoffrey G Glidden MD PA

New Patient Information

Name_____
Address_____
City/State/Zip_____
Cell Phone_____
Home Phone_____
DL#_____
SSN#_____

Age_____ Date of Birth_____ Sex: Male / Female

Your employer _____
Occupation_____
Work Phone_____

E-Mail_____

Referring Physician_____
Referring Phone #_____

Family Physician_____
Family Physician Phone #_____

Circle one:
Married / Divorced / Widowed/ Single / Other

Spouse_____
Spouse Cell Phone_____
Spouse Employer_____
Spouse Work Phone_____

If not married:
Nearest Relative Name_____
Phone Number_____

If Patient under 18 years old

Father's Name_____
Father's Birthday_____
Father's SSN_____
Father's Address_____
City/Stat/Zip_____
Father's Employer_____
Work Phone_____

Mother's Name_____
Mother's Birthday_____
Mother's SSN_____
Mother's Address_____
City/Stat/Zip_____
Mother's Employer_____
Work Phone_____

Primary Insurance

Insured by: Self / Spouse / Parent
Insurance Co._____
Insurance Type: Group / Individual
Member ID #_____
Group #_____
Policy Holder's Name _____
Policy Holder's SSN #_____
Policy Holder's D.O.B._____
Medicare #_____

Secondary Insurance

Insured by: Self / Spouse / Parent
Insurance Co._____
Insurance Type: Group / Individual
Member ID #_____
Group #_____
Policy Holder's Name _____
Policy Holder's SSN #_____
Policy Holder's D.O.B._____
Medicare # _____

Was this an Accident? Yes / No On the Job? Yes / No Date of Injury_____
Date of Previous Injury to same body part _____

_____

Patient/Guardian Signature Date

Pharmacy Name: _____ Pharmacy Number:_____

Past Medical History

Primary care physician:_____ Date of last exam:_____

Please check if you have had any of the following:

☐ **None**

- ☐ Childhood diseases
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Seizures
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Emphysema
- ☐ HIV / AIDS
- ☐ Broken bones
- ☐ Colitis
- ☐ Urinary infections
- ☐ Blood transfusions
- ☐ Scoliosis
- ☐ High blood pressure
- ☐ Pneumonia
- ☐ Psychiatric problems
- ☐ Osteoporosis
- ☐ Thyroid disease
- ☐ Leg length inequality
- ☐ Bleeding problems
- ☐ Liver disease
- ☐ Heart problems
- ☐ Gout
- ☐ Hepatitis
- ☐ Lupus
- ☐ Kidney disease / stones
- ☐ Rheumatic fever
- ☐ Blood clots
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis

If other conditions, please list:_____

_____

Women

Are you pregnant? (circle) Yes / No

Surgical History

Please list all surgeries with approximate year according to the categories listed:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Name Date

Medication Record

Please list current prescriptions, over-the-counter medications, and alternative remedies
If you cannot remember all of your medications, check here ☐
Always bring an updated medication list to all future appointments

☐ No Medications

Medication Name	Dose	Route	How Often

Allergies

Please indicate your medication allergies and the reaction to each medication.

☐ No Allergies

Medication	Reaction Type

Social History

Please circle or fill in the blank:

Sex: Male / Female Height: ____ft _____in Weight: _____ lbs

Marital Status: Married / Single / Divorced / Widowed

Children: Yes / No How many? _____

Have you ever required a blood transfusion? Yes / No Date _____ Number of units ____

Have you ever smoked? Yes / No If so, How much _____ and how long _____

Do you drink alcohol? Yes / No How many drinks per week? _____

Have you ever had problems with drug / alcohol use? Yes / No

Job description:_____

Patient Name _____ Date

Review of Systems

Please Circle Symptoms:

If none check here ☐

General: recent weight changes, fever, weakness, fatigue, headaches

Skin: rashes, eruptions, dryness, jaundice, changes in skin/hair/nails, discoloration, swelling

Eyes: blurred vision, double vision, burning eyes

Ears/Nose/Throat: hoarseness, difficulty swallowing, Head colds, nasal drainage, obstruction, sinus pain, ear ache, hearing loss, hearing aids

Musculoskeletal: joint pain, swelling, stiffness, deformity

Pulmonary: difficulty breathing, asthma, bronchitis, Pneumonia, shortness of breath

Neurological: fainting, paralysis, dizzy spells, numbness

Cardiovascular: chest pain, rheumatic fever, rapid heartbeat, Leg swelling, heart valve problems, varicose veins, heart attack

Endocrine: fatigue, hot or cold intolerance, excessive sweating, Thirst, hunger

Gastrointestinal: decrease in appetite, nausea, vomiting, Diarrhea, constipation, heartburn, hemorrhoids, reflux, blood in Stool, ulcers

Genitourinary: change in urinary frequency, urinary pain, blood in urine, difficulty voiding, incontinence

Hematological/Lymphatic: anemia, easy bruising or bleeding, Swollen glands

Psychological: nervousness, mood swings, insomnia, Depression,

Other: _____

_____

Family History

Please check if any of the following occur in your family:

☐ **None**

- ☐ Cancer
- ☐ Diabetes
- ☐ Seizures
- ☐ Stroke
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Thyroid disease
- ☐ Broken bones
- ☐ Bleeding problems
- ☐ Scoliosis
- ☐ Heart problems
- ☐ Lung problems
- ☐ Kidney problems / stones
- ☐ Osteoporosis
- ☐ Blood clots
- ☐ Liver disease
- ☐ Arthritis
- ☐ Gout
- ☐ Problems with general anesthesia
- ☐ Lupus

If other conditions occur in your relatives, please list _____

_____

_____ _____

Patient Name Date

_____ _____

Physician Verification Date

NEW PATIENT_____ PREVIOUS PATIENT_____

DATE_____

PATIENT NAME _____

WHAT IS THE REASON FOR BEING SEEN TODAY?

_____

_____

_____

NURSE/DOCTOR NOTES: