Cone Health Primary Care at MedCenter Greensboro at Drawbridge – New Patient Intake From

Name: _____ Date of Birth: _____
Nickname/Preferred Name: _____; Preferred Pronouns: she/her; he/him; they/them; other_____
Occupation: _____(employed/job, stay-at-home parent/caregiver, student, unemployed, etc)
Primary reason for today's visit: _____
Other concerns for a future visit: _____

Have any of the following symptoms been bothering you recently? (please circle any that apply)					
General: fever up to _____degrees chills unintended weight loss fatigue night sweat	**Head/Neck:** headache vision change hearing change sore throat voice change sinus pressure	**Cardiovascular**: chest pain chest pressure heart racing leg/foot swelling	**Respiratory**: trouble breathing dry cough cough w/ mucus bloody cough wheeze	**Gastrointestinal**: abdominal pain nausea vomiting blood in stool diarrhea constipation heartburn	**Musculoskeletal**: muscle pain joint pain back pain neck pain recent injury old injury w/ pain now
Skin: rash itching concerning mole new lumps /bumps hair/nail problem	**Genital/Urinary**: blood in urine leaking urine difficulty urinating genital bleeding genital discharge genital rash	**Blood/Lymph**: easy bruising easy bleeding large lymph node	**Hormonal**: feeling too cold feeling too hot increased thirst increased eating abnormal periods weight gain	**Neurological**: weakness arm/leg drooping face speech problem passing out dizzy/vertigo numbness/tingling	**Mental Health**: depression anxiety sleep problems mood swings drug use alcohol overuse
Other symptoms or problems not listed above:					

Medical History:				
Have you ever been diagnosed with any of the following? (please circle any that apply)				
Heart Attack High Blood Pressure High Cholesterol Heart Failure Atrial Fibrillation	Blood clot in leg Blood clot in lung Stroke Diabetes Kidney Disease	Low Thyroid High Thyroid Asthma COPD	Colon Polyps Abnormal Pap smear Abnormal Mammogram Cancer – type:	Depression Anxiety Other mental illness Drug use/addiction Alcohol use/addiction
Have you been hospitalized 24+ hours/overnight in the past year? Yes / No If yes, what was the problem?				
Other illness or illnesses not noted above:				

Medications: please include prescriptions, over-the-counter drugs, herbs, alternative treatments, etc. *You may attach a list.*	
Medication Name / Dose / Time of day you take it	Medication Name / Dose / Time of day you take it

Allergies & Side Effects: please list any medication you've had a bad reaction to, and please specify that reaction

Please complete back of form →

Substance Use History:	
Tobacco: Never/Current/Former tobacco use If cigarettes, #packs per day (average) _____ for _____ years If current smoker, would you like to quit? Yes/No	Type: Cigarette/Cigar/Pipe/Chew? If former smoker, when did you quit? _____ **Other**: ever used vape/e-cigarette? Yes/No
Alcohol: Never/Rarely/Sometimes/Often/Daily/Former If you drink, #drinks on average per week? _____ Do you or your loved ones think you drink too much? Yes/No	**Drugs:** Never/Rarely/Sometimes/Often/Daily/Former If drugs used, which ones have you used/do you use?

Sexually active?	**Partner(s) are or have been**:	**Sexually Transmitted Infection (STI):**	**Your Gender Identity**:	**Your Sexual Orientation**:
never not currently yes in past year: one partner 2+ partners	male female transgender other	**Any history of STI**? Yes/No If yes, specify:_____ **How are you preventing an STI?** Abstinence/ Condom/ Other_____ **Are you interested in being screened for an STI today?** Yes/No **Last time tested for STI:** _____	Female Male Trans Female Trans Male Non-Binary Other: _____ Choose not to say	Heterosexual Lesbian/Gay Bisexual Other:_____ Don't know/unsure Choose not to say

Family Planning:	**If applicable**:
Are you pregnant/breastfeeding now? Yes/No **Are you or your partner planning to become pregnant?** Yes/No **If no, how are you or your partner preventing pregnancy?** Abstinence/ condom/ pill/ patch/ ring/ IUD/ Nexplanon/ tubes tied/ vasectomy/ same-sex partner/ postmenopausal/ hysterectomy/ other: _____	Last Period: _____ #Pregnancies: _____ #Children: _____ #Miscarriages: _____ #Abortions: _____

Safety:	**Have you ever been physically/emotionally abused by a partner or someone important to you?** Yes/No If yes, when did this most recently happen? _____ Do you have help? _____

What surgeries have you had? (please circle any that apply)				
C-section(s) Hysterectomy	Tubes tied Vasectomy	Gallbladder removal Appendix removal	Joint replacement Broken Bone repair	Other:

Do any family members have the following illnesses, that you know of? Other: family history unknown If yes, please circle - specify (mother, brother, maternal grandfather, etc.)				
High Blood Pressure Heart Attack	Diabetes Stroke	Skin Cancer Colon Cancer	Breast Cancer Ovarian Cancer	Prostate Cancer Other Cancer
Other family illness or illnesses not noted above:				

Routine Cancer Screening: please tell us when you had the test, and where you had it so we can request records		
Colonoscopy, Cologuard or stool test to screen for colon cancer? _____ If you are 50 or older, and never had this test, please tell us the reason.	**Mammogram** to screen for breast cancer? _____ If you are 40 or older, and never had this test, please tell us the reason.	**Pap smear** to screen for cervical cancer? _____ If you are 21 or older, and never had this test, please tell us the reason.

Adult Immunizations: When was your last… (if uncertain, a guess or the approximate year is fine)			
Flu shot? _____ (Recommended every year)	**Tetanus shot?** _____ (Td/Tdap booster every 10 years)	**Shingles shot(s)?** _____ (Old vaccine was Zostavax, newer one is Shingrix)	**Pneumonia shot(s)?** _____ (Prevnar and Pneumovax if 65 or older, Pneumovax earlier if certain illnesses)

Thanks for taking this time to share this information! Welcome to Cone Health Primary Care! ☺