Patient Initial Visit Form

COPPOLA MEDICAL ASSOCIATES

PATIENT INFORMATION:

Name:________________________ Date of Birth: __________ Age: ____________

City | State | Zip Code: ____

Home Phone:______________Work Phone:______________Cell Phone ______________

Do we have permission to leave messages on your answering machine at: ❑ home ❑ work or ❑ cell phone(s).

Social Security Number: ____

In the event of an emergency, please contact:

Name: ______________________ Relationship:____________ Phone: ____________

INSURANCE:

Primary Insurance:______________________ ID Number: ______________________

Secondary Insurance:____________________ ID Number______________________

I take responsibility for all medical bills. I authorize the release of medical information necessary to process claims for medical benefits. I also authorize payment of medical benefits directly to Coppola Medical Associates, Ltd. for services provided

____

Signed Date

MEDICAL HISTORY:

List all problems/past surgeries that you are aware of:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________
13. ______________________

Do you have, or have you experienced:	Yes	No	When?
Rashes	❑	❑	______
Bruises	❑	❑	______
Headaches	❑	❑	______
Blurred Vision	❑	❑	______
Swollen Glands	❑	❑	______
Weakness	❑	❑	______
Earaches	❑	❑	______
Shortness of Breath	❑	❑	______
Wheezing	❑	❑	______
Exposure to TB	❑	❑	______
Chronic Cough	❑	❑	______
Chest Pains	❑	❑	______
Palpitations	❑	❑	______
Weight Loss/Gain	❑	❑	______
Abdominal Pain	❑	❑	______
Joint Pain	❑	❑	______
Leg Cramps	❑	❑	______
Bleeding	❑	❑	______
Blood Transfusion	❑	❑	______
Hepatitis	❑	❑	______
Usual Childhood Illness	❑	❑	______
Change in Bowel Movement	❑	❑	______
Change in Urinary Habits	❑	❑	______
Vaginal/Penile Discharge	❑	❑	______
Psychiatric Illness	❑	❑	______

COPPOLA MEDICAL ASSOCIATES

Patient Initial Visit Form

MEDICAL HISTORY:

Please describe any medical problems your mother, father, sister(s), or brother(s) have or may have had. If applicable, list age, cause of illness and date of death.

____

____

____

____

____

____

____

____

PERSONAL:

With whom do you live?______________ Relationship: ______________

What is your occupation?

Are you working? ❏ yes ❏ no If yes, who is your employer? ______________

Are you retired? ❏ yes ❏ no

Do you smoke? ______________ How much? ______________

Do you drink: ______________ How much? ______________

Do you use recreational drugs? ______________ What/How Often/ ______________

Are you sexually active? ______________

FOR WOMEN ONLY:

How many pregnancies have you had?

How many live births? ______________

Do you use birth control ? ❏ yes ❏ no If yes, what type?______________

Date of last menstrual cycle:______________

Date of last pap smear:

Date of last mammogram: ______________