

RIDGE MEDICAL ASSOCIATES, LLC
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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of Birth: _____ Today's date: _____

Welcome to Ridge Medical Associates, LLC. Please take a few minutes to fill out the information below. By filling the form completely and accurately, you will assist greatly in providing high quality care to you. If you have any questions, please ask one our staff members.

1. What is the reason for your visit today? _____

2. Do you suffer from any medical conditions or disease? Please check all that apply:

- High blood pressure Diabetes (high blood sugar) Hyperlipidemia (cholesterol disorders)
- COPD (emphysema) Asthma Coronary artery disease (blockage in heart)
- Heart failure artificial heart valve Atrial fibrillation (irregular heartbeat)
- Irritable bowel syndrome Colon polyps Cancer, type _____
- Anemia (low blood) arthritis Hypothyroidism (underactive thyroid)
- Other conditions not mentioned above: _____

3. Have you had any surgeries? If yes, please tell us what kind and when they were done:

4. Are you currently experiencing or have you recently experienced any of the following symptoms? Please check all that apply:

- Weight Loss Fever Chills Shortness Of Breath Chest Pain Cough Nausea Vomiting Diarrhea
- Blood In Stools Abdominal Pain Urinary Frequency Burning With Urination Blood In Urine
- Joint Pains Falls Loss Of Balance Dizziness Tingling/Numbness Blurred Vision Anxiety Depression Suicidal Thoughts Hearing Voices Loss Of Memory Confusion

5. Do you smoke? Yes _____ packs a day Never smoked Past smoker (quit _____ years ago)

6. Do you drink alcohol? Yes, I drink regularly occasionally heavily
 No Past use

