MANHATTAN PRIMARY CARE

Telephone: (212) 378-9987
www.manhattanprimarycaredoctorsnyc.com

Name: _____ **DOB:** _____

Email: _____
How did you hear about us: o Referring Doctor o Zocdoc o Yelp o Internet o Other ____
Referring Physician : _____
Primary Care Physician _____ Telephone Number: _____
In case of emergency, please notify: _____ Relation_____ Telephone _____
Please explain briefly why you are here today: _____

Current Medication: (including over the counter, prescription, birth control pills)

Name, Dose and Frequency	Name, Dose and Frequency
1.	1.
2.	2.
3.	3.

Pharmacy name and telephone:

Medical History (please list) **o None**
1.
2.
3.
4.
5.

Surgical /Hospitalization History o None

Description	Year	Reason

Family History		
Relation	Age	Medical issues
Father		
Mother		
Brothers		
Sisters		
Any family history of gastrointestinal cancer? oNo oYes If yes, what type of cancer and whom? _____		
Any family history of Crohn's Disease, Ulcerative colitis or Celiac Disease? oNo oYes If yes, whom_____		
Any family history of skin cancer? oNo oYes If yes, what type of cancer and whom? _____		

Allergies **o No Known Allergies**

Medication	Reaction

Social History

Occupation:_____
Marital Status: o Single o Married o Divorced o Widowed
Children: o No o Yes
Sexual Orientation (info required for appropiate screening) o Heterosexual o Homosexual o Bisexual o Other:
Have you been diagnosed with any sexually transmitted disease or HIV/AIDS? o No oYes
Do you smoke? o No o Yes
How many alcoholic drinks per week? o less than ten o more than ten

OFFICE USE ONLY	
Email	
PCP	
Address	
Pharmacy	
Consent Forms	
Initials	

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Patient Name: _____

Review of Systems

GASTROINTESTINAL	NO	YES
Abdominal Pain	☐	☐
Anemia	☐	☐
Blood in Stool/ Blood when Whiping	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heartburn/Reflux	☐	☐
Difficulty Swallowing	☐	☐
Hemorrhoids	☐	☐
Ulcerative Colitis/ Crohn's Disease	☐	☐
Irritable Bowel Syndrome	☐	☐
Bloating/Pain after Eating	☐	☐
Anal Warts	☐	☐
Colon Polyps	☐	☐
Narrow Stools/Change of Bowel Habits	☐	☐

EYE	NO	YES
Blurry Vision	☐	☐
Change in Vision	☐	☐
Dry Eyes	☐	☐
Issues with Glasses	☐	☐
Dry Eyes	☐	☐
Flashing Lights	☐	☐
Floaters	☐	☐
Vision Loss	☐	☐

PODIATRY	NO	YES
Foot Pain	☐	☐
Heel Pain	☐	☐
Ankle Pain	☐	☐
Hammertoes	☐	☐
Bunions	☐	☐
Fungus/Problems	☐	☐

DERMATOLOGY	NO	YES
Rash/Spots	☐	☐
Acne	☐	☐
Eczema	☐	☐
Hair Loss	☐	☐

Preventive Care

What year was your last colonoscopy?	oNever	GYN Exam within the last 12 months	o Yes o No
What year was your last mammogram?	oNever	Skin Exam within the last 12 months	o Yes o No
		Eye Exam within the last 12 months	oYes o No

INTERNAL USE ONLY

GI: Appt Date _____

GYN: Appt Date: _____

EYE: Appt Date _____

DERM Appt Date _____

Podiatry: Appt Date _____

Follow Up with MD: _____

Next appoint ment in :

☐ **Day**
☐ **Week**
☐ **Month**

if no follow-up, please set alert for "follow up appointment needed"

Imaging: US- Abdomen US Abdomen and Pelvis US Transvaginal

Other: Labs Stool Occult