CRAIG P. PROKOS, M.D.

NEW PATIENT INFORMATION

DATE: _____ E-MAIL ADDRESS _____

Patient's Name : _____ SS# _____

Sex ____ Age ____ Date of Birth _____ Marital Status S ___ M ___ W ___ D ___

Local Address: _____ Phone: _____

_____ _____ _____ Cell Phone _____
(City) (State) (Zip)

Out of state address: _____ PHONE _____
Patient's Employer: _____ Occupation _____
Employer's Address: _____ Bus Phone _____
Spouse Name: _____ SS # _____
Spouse Employer: _____ Occupation _____
Employer Address: _____ Bus Phone _____
Nearest Relative (not living in household) _____
Address: _____

Illness or Injury related to: Work _____ Auto Accident _____ Other _____

INSURANCE INFORMATION:

MUST HAVE INSURANCE CARD

PRIMARY LANGUAGE SPOKEN: _____

DO YOU HAVE A LIVING WILL (ADVANCED DIRECTIVES) Yes ____ No ____
TELL US IF YOU WANT ONE.

AUTHORIZATIONS:

I hereby authorize Dr. Prokos to release any information acquired in the course of my treatment to my insurance company. I request that payment of authorized benefits be made either to me or on my behalf for any services furnished me by Dr. Prokos (MEDICARE PATIENTS) I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

DATE: _____ SIGNATURE: _____

YOUR MEDICAL HISTORY

The Doctor would like to know your past medical history in order to understand how he can help you. The information you give on this form will be kept confidential, for our files in this office only. The information will not be released to anyone else, unless you request the release in writing.

NAME _____ DATE _____

REFERRED BY _____

1. When was your last medical checkup? _____

   Why are you here to see the Doctor today?

_____

_____

2. Have you been hospitalized or had surgery in your lifetime? Yes _____ No _____

FOR WHAT?	WHEN? MONTH	WHEN? YEAR

3. Have you had any other illnesses or injuries during your lifetime?

WHAT ILLNESS?	WHEN? MONTH	WHEN? YEAR

4. Medications _____

_____

5. Allergies _____

NAME: _____

Health Maintenance:

Do you take Aspirin? Yes _____ No _____

Have you had a colonoscopy? Yes _____ No _____ When? _____

Have you had the Pneumonia vaccine (Pneumovax) Yes _____ No _____ When?_____

Have you had a mammogram? (if **female**) Yes _____ No _____ When?_____

Have you had a breast exam? (if **female**) Yes _____ No _____ When? _____

Date of last gynecologic exam? (if **female**) _____

Date of last Digital Rectal Exam? (if **male**) _____

Have you had a PSA? (if **male**) Yes _____ No _____ When? _____

SOCIAL HISTORY: Do you have regular exercise habits? Yes ____ No ____.

Do you sleep regularly? Yes ____ No ____. Eat well-balanced meals? Yes ____ No ____.

A. Do you smoke? _____ How Long? _____ How Much? _____

B. Have you ever smoked? ____ When did you quit? _____

C. Do you drink? _____ How Much per week? _____

FAMILY HISTORY:

Mother living? _____ age _____ (or) died at age _____ Cause _____

Father living? _____ age _____ (or) died at age _____ Cause _____

Brothers living? _____ # deceased _____ age at death ____ Cause _____

Sisters living? _____ # deceased _____ age at death ____ Cause _____

Does anyone in your immediate family have heart disease, diabetes or cancer? _____

If so, please explain _____

When form is completed, Save the document on your computer and attach it to an e-mail and send it to:

INTMED@BELLSOUTH.NET

Thank you.