CNY FAMILY CARE ADULT PATIENT INTAKE FORM

Welcome to CNY Family Care! We are pleased to serve your health care needs and those of your family. In order to assist our providers and staff, please complete this information to the best of your ability.

Today's Date**:** ___/____/____ **Patient Name**: _____ Date of Birth: ____/_____/_____

Sex at birth: ❑Male ❑Female Current sex: ❑Male ❑Female

Current Gender Identification: ❑Male ❑Female ❑Transgender Male ❑Transgender Female ❑Non-binary

SS#: _____ Patient Email Address: _____

Address: _____
Street City/Town State Zip code

Home Phone: _____Cell Phone: _____Work Phone: _____Ext.: _____

Who Completed this form? ❑ Patient ❑ Spouse ❑ Other Name (if other than patient): _____

Emergency Contact: _____ (____)_____
Name Relationship Phone Number

Primary Insurance Carrier: _____ Policy Holder Name: _____

Policy Number: _____ Your relation to Policy Holder: _____

Secondary Insurance Carrier: _____ Policy Holder Name: _____

Policy Number: _____ Your relation to Policy Holder: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize CNY Family Care or insurance company to release any information required to process claim.

Patient signature: _____ **Date**____/_____/_____

Former Primary Care Provider: _____(____)_____
Name Address Phone number

Gynecologist (if applicable): _____(____)_____
Name Address Phone number

Please list below any specialists you see, OR have seen, and their contact information (phone number, address):

_____

_____

_____

_____

ADVANCE DIRECTIVES

Do you have a living will? ❑ Yes ❑ No

Do you have a health care proxy? ❑ Yes ❑ No Name/ Phone# _____

Have you designated someone "Power of Attorney"? ❑ Yes ❑ No Name/ Phone# _____

Patient Name: _____ **Date of Birth** _____/_____/_____

Have you issued an order indicating "Do Not Resuscitate" (DNR)? ❑ Yes ❑ No

IMPORTANT: We ask that you bring your physician a copy of any documentation you have available regarding the above advance directives at your first appointment.

IMMUNIZATION HISTORY

Have you received the following IMMUNIZATIONS? If yes, indicate the approximate year it was last given:

Hepatitis A	❑Unknown ❑Yes ❑No Year_____	Hepatitis B	❑Unknown ❑Yes ❑No Year_____
Tetanus/ Diphtheria	❑Unknown ❑Yes ❑No Year_____	Influenza (Flu)	❑Unknown ❑Yes ❑No Year_____
Shingles	❑Unknown ❑Yes ❑No Year_____		

IMPORTANT: We ask that you bring a copy of your immunization record with you to your first appointment.

ALLERGIES

Have you had an allergic reaction to?

Iodine or X-ray contrast dye	❑ No ❑ Yes
Latex	❑ No ❑ Yes
Bee or wasp stings	❑ No ❑ Yes
Adhesive tape	❑ No ❑ Yes

Have you had hives, skin rash, breathing problems, or other allergic reactions to medications?
❑ No ❑ Yes→ Describe below:

Name of Medication **Describe Allergic Reaction**

_____

_____

_____

_____

Are there medications, other than those you are allergic to, that you would prefer not to use due to prior unpleasant side effects (example: GI upset)? ❑ No ❑ Yes→ Describe below:

Name of Medication **Describe Unpleasant side effect(s)**

_____

_____

_____

_____

Do you have any food allergies? ❑ No ❑ Yes→ ❑Cow's Milk ❑Eggs ❑Tree Nuts ❑Peanuts ❑Shellfish ❑Wheat ❑Soy ❑Other food allergy: _____

MEDICATIONS

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, birth control, pain relievers, diuretics, laxatives, and herbal remedies?
❑ No ❑ Yes→ List medications below:

Patient Name: _____ **Date of Birth** _____/_____/_____

Name of Medication	Dose	How Often Taken	Reason for Use

HEALTH MAINTENANCE HISTORY

Have you received the following HEALTH MAINTENANCE? If yes, indicate date of last exam/ test and who performed.

Bone Density Test/ DEXA	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Cardiac Stress Test	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Cologuard	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Colonoscopy	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Dental Exam	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Eye Exam	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
EKG	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Hepatitis C Screening	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Low-Dose CT Scan Lung Cancer Screening	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Mammogram	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
PSA Test (prostate blood test)	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
PAP Test	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Pelvic Exam	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Physical (complete) exam	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Rectal Exam	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Sleep Study	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____
Tuberculosis (TB) Test	❑ Unknown	❑ Yes ❑ No	Date: _____	Where: _____

CHILDHOOD ILLNESS

Indicate if you have had:

Any serious childhood Illnesses? ❑ None ❑ Chickenpox ❑ Measles ❑ Meningitis ❑ Mumps ❑ Pertussis
❑ Poliomyelitis ❑ Rheumatic Fever ❑ Rubella ❑ Other: _____

Patient Name: _____ **Date of Birth** _____/_____/_____

Medical Problems Review

Have you ever had any of the following?	No	YES	Describe the problem when appropriate
Abnormal chest x-ray _____	❑	❑	_____
Abnormal PAP Test _____	❑	❑	_____
Alzheimer's or Dementia _____	❑	❑	_____
Anxiety, depression, or mental illness_____	❑	❑	_____
Blood problems (abnormal bleeding, anemia, clots, high or low white count) _____	❑	❑	_____
Diabetes _____	❑	❑	_____
Growth removed from the colon or rectum (polyp or growth) _____	❑	❑	_____
Heart Attack _____	❑	❑	DATE(s): _____
High blood pressure _____	❑	❑	_____
High cholesterol or triglycerides _____	❑	❑	_____
HIV/ AIDS_____	❑	❑	_____
Mononucleosis_____	❑	❑	_____
Multiple Sclerosis _____	❑	❑	_____
Parkinson's _____	❑	❑	_____
Pacemaker or AICD (Internal Defib) _____	❑	❑	_____
Scarlet Fever or Rheumatic Fever _____	❑	❑	_____
Sexually transmitted disease _____	❑	❑	_____
Shingles_____	❑	❑	_____
Stroke or TIA _____	❑	❑	_____
Treatment for alcohol and/or drug abuse _____	❑	❑	_____
Tuberculosis or positive tuberculin skin test _____	❑	❑	_____
Cosmetic or plastic surgery _____	❑	❑	_____

Have you ever had a serious Accident(s)/ Injurie(s)?

❑ NO ❑ Auto Accident ❑ Head Injury ❑ Work Injury ❑ Sports Injury ❑ Other: _____

Indicate whether you have ever had a MEDICAL PROBLEM AND/OR SURGERY related to each of the following by placing a check (√) in the appropriate boxes. If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	No Problem	Medical Problem	Had Surgery	Year(s) of Surgery	Describe
Eyes (cataracts, glaucoma)	❑	❑	❑		
Ears, nose, sinuses, tonsils	❑	❑	❑		
Thyroid or parathyroid glands	❑	❑	❑		
Heart valves, heart rhythm	❑	❑	❑		
Coronary (heart) arteries (angina)	❑	❑	❑		
Arteries (aorta, arteries to head, arms, legs)	❑	❑	❑		
Veins, blood clots in the veins	❑	❑	❑		
Lungs (COPD, Emphysema)	❑	❑	❑		
Esophagus or stomach (ulcer)	❑	❑	❑		
Bowel (small & large intestine) Appendix)	❑	❑	❑		
Liver or gall bladder (including Hepatitis)	❑	❑	❑		

Patient Name: _____ **Date of Birth** _____/_____/_____

MEDICAL PROBLEM AND/OR SURGERY CONT.

	No Problem	Medical Problem	Had Surgery	Year(s) of Surgery	Describe
Hernia	❑	❑	❑		
Kidneys or bladder	❑	❑	❑		
Bones, joints, muscles (fractures)	❑	❑	❑		
Back, neck, spine	❑	❑	❑		
Brain (seizure disorder, Migraines)	❑	❑	❑		
Skin (cancer, eczema, acne)	❑	❑	❑		
Breasts	❑	❑	❑		
FEMALES: uterus, tubes, ovaries	❑	❑	❑		
MALE: prostate, penis, testes, vasectomy	❑	❑	❑		
Other: (please describe)	❑	❑	❑		

Ever had Anesthesia Complication(s)? ❑ No ❑ Yes→ ❑ Malignant Hyperthermia ❑ Seizure ❑ Arrhythmia ❑ Nausea ❑ Vomiting ❑ Other: _____

Hospitalizations

Have you ever been hospitalized? ❑ No ❑ Yes→ Describe below

Year	Reason	Facility (Name and address if out of local area)

ASSISTIVE DEVICES

Please indicate if you currently require any assistive devices.

Brace(s):	❑ knee	❑neck	❑ wrist	❑ back
Lifeline/ Medical Alert Device ❑				
Sleep Apnea Device	❑CPAP	❑BIPAP		
Cane-Standard:	❑ Standard cane used in left hand		❑ Standard cane used in right hand	
Cane-Quad:	❑ Quad cane used in left hand		❑ Quad cane used in right hand	
Contacts:	❑ Soft contact		❑ Hard contacts	
Crutches:	❑ Axillary crutches (arm pit)		❑ Forearm crutches	
Dentures-Complete:	❑ Complete Lower	❑ Complete Upper	❑ Complete Upper & Lower	
Dentures-Partial:	❑ Partial Lower	❑ Partial Upper	❑ Partial Upper and Lower	
Glasses:	❑ Glasses	❑ Bifocals	❑ Trifocals	
Hearing Aid:	❑ bilateral	❑ left	❑ right	
Walker:	❑ rolling	❑ standard walker	❑ rolling with platform	
Wears Corrective Shoes:	❑ bilateral feet	❑ left foot	❑ right foot	
Wheelchair:	❑ Manual	❑ Electric		

❑ **NONE** (I do not use any assistive devices)

Patient Name: _____ **Date of Birth** _____/_____/_____

OBSTETRIC/ GYNECOLOGIC HISTORY FOR WOMEN

Total Number of Pregnancies (viable and nonviable) in lifetime: _____ Total number of living children: _____

Full Term babies: _____ # Premature babies: _____ # Miscarriages (spontaneous abortions): _____

Elective termination of pregnancy(s): _____ Age of menopause: _____ ❑NA/ I have not reached menopause

Age of first menstrual period: _____ Date of last menstrual period: _____ Period Frequency: _____ #of days: _____

Current Contraceptive Method(s): ❑None ❑Abstinence ❑Coitus Interruptus ❑Female Condoms ❑Male Condoms ❑Depo-Provera Injection ❑Diaphragm ❑Essure ❑IUD-Copper (Paragard) ❑IUD-Levonorgestrel (Mirena, Kyleena, Liletta, Skyla) ❑Oral Contraceptive (pill) ❑Patch ❑Rhythm Method ❑Ring (Nuva) ❑Spermicides ❑Tubal Ligation ❑Vasectomy

FAMILY HISTORY MEDICAL ISSUES

Place a check mark (√) in the appropriate boxes to identify all illnesses/conditions **which you know have occurred** in your **blood relatives**. Check "NONE" if you are not aware of any relative having the illness/condition. Describe the illness or condition.

Illness/Condition	Family Members									Describe
	Father	Mother	Brothers	Sisters	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	None	
Immune Problems, HIV, AIDS										
Alcoholism										
Addiction - Drugs										
Anemia										
Arthritis (childhood) (JRA)										
Birth Defects										
Bleeding Disorder or Clotting Disorder										
Crohns or ulcerative colitis										
Developmental Delay										
Diabetes										
Epilepsy or Convulsions										
Heart Disease (before 50 years old)										
High Blood Pressure (before age 50)										
Kidney Disease										
Liver Disease										
Mental Illness										
Intellectual Disability (Mental Retardation)										
Thyroid Disease										

Other information about your family which you want us to know: _____

_____

_____

Patient Name: _____ **Date of Birth** _____/_____/_____

Are you adopted? ❑ Yes → If known, complete the following information below about your **blood** relatives (include children). Exclude adoptive parents, siblings and adopted children.

❑ No → Complete the following information about your **blood** relatives. Exclude adoptive siblings and adopted children.

Father ❑Alive ❑Deceased (Age_____) ❑Unknown Cause(s) of Death: _____

Mother ❑Alive ❑Deceased (Age_____) ❑Unknown Cause(s) of Death: _____

How many children to you have? _____ How many siblings do you have? _____

	Number Alive	Number Deceased	Approximate Age(s) at Death	Causes(s) of Death	History Unknown
Sons	_____	_____	_____		❑
Daughters	_____	_____	_____		❑
Brothers	_____	_____	_____		❑
Sisters	_____	_____	_____		❑
Paternal Grandmother	_____	_____	_____		❑
Paternal Grandfather	_____	_____	_____		❑
Maternal Grandmother	_____	_____	_____		❑
Paternal Grandfather	_____	_____	_____		❑

SOCIAL HISTORY

Marital Status? ❑Divorced ❑Domestic Partner ❑Married ❑Significant Other ❑Single ❑Widowed

What is your current living arrangement?
❑Apartment ❑Assisted Living Facility ❑Car ❑Friend's Home ❑Relative's Home ❑Group Home ❑House
❑Homeless-living on street ❑Homeless-staying in shelter ❑Nursing Home/ Long Term Care Facility ❑Trailer

Who lives with you? _____ **❑No one lives with me (I live alone)**

Do you have pets? ❑Dogs (#: ___) ❑Cats (#: ___) ❑Other Type: _____ (#: ___)

Are you exposed to tobacco or marijuana smoke in your home? ❑Yes ❑No

Are you exposed to tobacco or marijuana smoke at work? ❑Yes ❑No

Are their guns in your home? ❑No ❑Yes, locked Up ❑Yes, Not locked up

Patient Name: _____ **Date of Birth** _____/_____/_____

Highest Education Level Completed? ❑ Elementary school (grade: _____) ❑ Grade school (grade: _____)
❑High School ❑ Associates Degree ❑Bachelor's Degree ❑Master's Degree ❑Doctorate Degree
❑ Vocational Degree (vocation: _____) ❑ College – 1 year ❑ College – 2 years

BARRIERS TO CARE

Please indicate if any of the following will affect your ability to receive treatment at our practice?
❑Education status ❑Family responsibilities ❑Financial Hardship ❑Geographic location
❑Insurance status ❑Language ❑Transportation ❑Work Hours
❑**None Identified** – I am not experiencing anything affecting my ability to receive treatment at CNY Family Care

Are you currently experiencing any of the following social determinants?
❑Difficulty accessing transportation ❑Difficulty affording transportation ❑Homebound (cannot leave home)
❑Homelessness ❑Limited access to nutritious food ❑Uncertain access to nutritious food
❑Unsafe housing quality
❑**None Identified** – I am not experiencing any of these

Please indicate if any of the issues below are affecting your social functioning:
❑Absence of Social Engagement ❑Anxiety/Depression ❑Declining Health/Cognition ❑Isolation
❑Inability to maintain an adequate social life ❑Lack of family network ❑Lack of friend network
❑**None Identified** – I am not experiencing any of these

Please indicate if you have any learning barriers:
❑Intellectually disabled ❑Cognitive ability impaired ❑Deafness-complete ❑Hearing impaired
❑Impaired memory ❑Unable to read ❑Unable to understand when you read ❑Vision Impaired
❑Legally Blind
❑**None Identified** – I do not have any barriers which affect my ability to learn

Please indicate if you have any communication barriers:
❑Primary language is not English ❑Needs a translator at medical appointments ❑Deafness-complete
❑Hearing impaired ❑Needs an American Sign Language (ASL) interpreter at medical appointments
❑Nonverbal (does not speak) ❑Legally blind
❑**None Identified** – I do not have any barriers which affect my ability to learn

Current employment status: ❑Employed ❑Work w/restrictions ❑Retired ❑Medically retired
❑Unemployed ❑Disabled (cause of disability: _____)

What is your occupation? _____ Employer Name: _____

Employer
Address: _____
Street City/Town State Zip code

Are you on a special diet? ❑ No ❑ Yes→ ❑Diabetic diet ❑Renal diet ❑Mechanical soft ❑Vegan
❑Vegetarian ❑Other: _____

Are you receiving any community services?
❑No/None ❑Day Service Program ❑Home Care ❑Homemaking services (aid for cleaning, cooking, laundry) ❑Meals on Wheels ❑Medical Transport Services/ Assistance ❑Occupational Therapy ❑Physical Therapy ❑Speech Therapy ❑Volunteer comes into the home ❑Other: _____

Are you <u>currently</u> experiencing any abuse? ❑No ❑Yes-Bullying in school ❑Yes-Domestic Violence
❑Yes-Emotional abuse ❑Yes-Physical abuse ❑Yes-Sexual abuse

Patient Name: _____ **Date of Birth** _____/_____/_____

Have you been abused in the past? ❑No history of abuse ❑Yes-Bullied in school ❑Yes-Domestic Violence ❑Yes-Emotionally abused ❑Yes-Physically abused ❑Yes-Sexually abused

Self-Care Assessment

Place a check mark (√) in the appropriate boxes to identify if you are independent with the activity, dependent on another individual, or require assistance to perform the activity. If you are dependent on an individual, or require assistance to perform the activity, please indicate who provides you with assistance.

Activities of Daily Living and Instrumental Activities of Daily Living	Independent	Dependent	Requires Assistance	Indicate who helps you perform this activity
Ambulating (walking)				
Bathing				
Dressing				
Feeding				
Grooming				
Standing				
Toileting				
Cleaning				
Cooking				
Laundry				
Medication Management				
Money				

PERSONAL HABITS

Do you currently smoke tobacco? ❑Yes – every day ❑Yes – some days ❑Former tobacco smoker (quit) ❑Never smoked tobacco

Do you currently smoke marijuana? ❑Yes – marijuana every day ❑Yes – marijuana on some days ❑Former marijuana smoker (quit) ❑Never smoked marijuana

What type of tobacco do you currently use?
❑N/A- I do not use tobacco at this time ❑Cigarette ❑Cigar ❑Pipe ❑Smokeless tobacco (chew, snuff)

What is the amount/frequency of your current tobacco use? # Cigs Per Day: _____ # Packs per day: _____

What year did you start to use tobacco? _____ **How many total years have you used tobacco?** _____

Are you a former tobacco user? ❑ No ❑ Yes→ Tobacco Type: _____ Amount/ Frequency: _____
When did you QUIT? _____ When year did you start? _____

Do you smoke an E-Cigarette (Juul, Vape)? ❑ Never used ❑ Current E-Cig smoker ❑ Former E-Cig smoker

Have you used alcohol in the past 12 months? ❑No ❑Yes

How often do you drink an alcoholic beverage?
❑I deny alcohol use ❑ I have never used alcohol ❑ Daily ❑Occasionally ❑Rarely

Patient Name: _____ **Date of Birth** _____/_____/_____

How many alcoholic beverages to you currently drink? Per Day: _____ Type: _____ Per Week: ____ Type:_____

If you have quit using alcohol, what was your former alcoholic beverage use frequency?
❑ N/A – (I still drink alcohol) ❑ Daily ❑ Occasionally ❑ Rarely

Have you used recreational drugs (street drugs) or prescription drugs other than those prescribed to you in the past 12 months? ❑ No/ I deny current drug use ❑ Yes→ Specify Drug(s): _____

How often are you <u>currently</u> using recreational/street drugs or prescription drugs other than those prescribed to you? ❑Never ❑Regularly ❑Sporadically ❑Daily Use (addiction)

Have you ever used IV Drugs? ❑ No ❑ Yes **Have you ever been to rehab?** ❑ No ❑ Yes

Are you a former recreational drug (street drug) user or former user of prescription drugs other than those prescribed to you? ❑ No/ I deny former drug use ❑ Yes→ Specify Drug(s): _____

How many caffeinated beverages to you currently drink? Per Day: _____ Type: _____ Per Week: ____Type: _____

Current Exercise? ❑ No/ None ❑ Yes→ Type: _____ Frequency: ❑Regular ❑Rare ❑Sporadic

In an automobile how often do you use a seat belt? ❑ Always ❑ Never ❑ Sometimes

If you ride a bike how often do you wear a helmet? ❑Always ❑Never ❑Sometimes ❑I do not ride a bike

I have completed this Adult Intake Form to the best of my ability -

Signature of Patient: _____ **Date:** ____/____/_____

Other Signature (if not patient completing this form): _____ **Date:** ____/____/_____