Established Patient Routing Form

Appointment Time: _________ Arrival Time: _________ Dr. seeing today: **Sewall** **Miley** **Bunge** **Hafner**

Patient Name: ____Patient Birth date: _____________________________

Patient Mailing Address (P O Box):____ Patient Phone No.______________

Insurance Company Name: ____ Patient's sex: **Male** **Female**

What Pharmacy do you use?_________________________________ Email Address:________________________________

ARE YOU ON ANY MEDICATION? YES NO. If yes, please list below:

Name of Medication	Dosage	Reason

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO. If yes, please list below:

Name of Medicine	Type of Reaction

If you are an allergy patient, are you getting your allergy injection today? YES NO

Are you allergic to Penicillin? **YES** **NO** If so, are you interested in being Penicillin allergy tested **YES** **NO**

If you are 50 or over, have you had a colonoscopy? **YES** If so, **Month** _________ **Year** ________ **NO**
If you are 65 or over, have you had a Pneumonia Vaccination? ____**YES** If so, **Month** _________ **Year** _________ **NO**
___
Have you been ***diagnosed with any new illness*** since your last visit? **YES** **NO** (If yes, please list)

Have you been ***hospitalized*** or had any new ***surgeries*** since your last visit? **YES** **NO** (If yes, please complete the following)

Have been hospitalized for:	New surgeries I have had:

Please circle any of the following that you now have or have recently had:

Fatigue	Sleeping Problems	Unintentional Weight Loss	Unintentional Weight gain	Dizziness	Frequent Headaches	Severe Face pain
Blurred Vision	Itchy eyes	Loss of Vision	Painful eye	Ear drainage	Hearing Loss	Ear Pain
Ringing in ears	Nasal Congestion	Frequent Nosebleeds	Post-Nasal Drainage	Belching sour material into throat	Hoarseness or other voice change	Mouth Ulcer
Partials or dentures	Blacking out or fainting	Chest Pain	Heart Murmur	Irregular Heartbeats	Leg Cramps	Swelling of ankles
Frequent non-productive cough	Frequent Productive cough	Stiffness in Joints	Swelling in Joints	Change in sense of taste	Seizures	Tremor
Appetite is increased	Cold Feeling	Bleed excessively after injury	Bruise easily	Masses in armpits	Masses in neck	Hives
						Sneezing

Current tobacco use? Yes O No O History of tobacco use? Yes O No O

Do you have a tobacco dependency with cigarettes or smokeless tobacco? O Yes O No

Are you exposed to second-hand tobacco smoke in your home? Yes O No O

Are you exposed to second-hand tobacco smoke in the work place? Yes O No O