Established Patient Routing Form

Appointment Time: _____ Arrival Time: _____ Dr. seeing today: ☐ **Sewall** ☐ **Miley** ☐ **Mandas** ☐ **Prusha**

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 teste ☐ **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 ○ No ○ History of tobacco use? Yes ○ No ○

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

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

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