**Northeast Medical Group**

**Dr. Andrew Kenler, MD**

Patient Information:

Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OB-Gyn Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiologist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:

Single  Married

Widow  Divorced

Patient Sex:

Female Male

**Please bring a photo I.D. and your insurance card to your doctor’s visit.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Method:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to leave a voicemail:  Yes  No

Permission to leave a message with another person:  Yes  No

Name of person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Information:

Tobacco Use:  Yes  No If yes: # of yrs: \_\_\_\_\_ Packs Per Day: \_\_\_\_\_

Quit Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Drug Use:  Yes  No If yes, please list type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use:  Yes  No If yes, # of glasses of wine *per week*: \_\_\_\_\_\_ beer: \_\_\_\_\_

shots of liquor: \_\_\_\_\_\_\_

Allergies: Allergy Reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical History:

AAA Repair:  Yes  No Hernia Repair:  Yes  No

Appendectomy:  Yes  No Hysterectomy:  Yes  No

Bladder Surgery:  Yes  No Joint Replacement:  Yes  No

Brain Surgery:  Yes  No Lung Surgery:  Yes  No

Breast Surgery:  Yes  No Small Intestine Surgery:  Yes  No

Bunionectomy:  Yes  No Spine Surgery:  Yes  No

CABG:  Yes  No Thyroid Surgery:  Yes  No

Cardiac Stent:  Yes  No Tonsillectomy:  Yes  No

Cholecystectomy:  Yes  No Tubal Ligation:  Yes  No

Colon Surgery:  Yes  No Valve Replacement:  Yes  No

C-section:  Yes  No Varicose Vein Surgery:  Yes  No

Eye Surgery:  Yes  No Vascular Surgery:  Yes  No

Fracture Surgery:  Yes  No Weight Reduction Surgery: Yes  No

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History:

Allergies:  Yes  No Heart Murmur:  Yes  No

Anemia:  Yes  No High Cholesterol:  Yes  No

Anxiety:  Yes  No HIV/AIDS:  Yes  No

Arthritis:  Yes  No Hypertension:  Yes  No

Asthma:  Yes  No Kidney Disease:  Yes  No

Blood Transfusion:  Yes  No Meningitis:  Yes  No

Cancer:  Yes  No Myocardial Infarction:  Yes  No

Cataracts:  Yes  No Nerve/Muscle Disease:  Yes  No

CHF:  Yes  No Osteoporosis:  Yes  No

Clotting disorder:  Yes  No Seizures:  Yes  No

COPD:  Yes  No Sickle Cell Anemia:  Yes  No

Depression:  Yes  No Stroke:  Yes  No

Diabetes Mellitus:  Yes  No Substance Abuse:  Yes  No

Emphysema:  Yes  No Thyroid Disease:  Yes  No

GERD:  Yes  No Tuberculosis:  Yes  No

Glaucoma:  Yes  No

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: Medication Dose and Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History:

Please check the box if a family member has a diagnosis listed.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mom | Dad | Sister | Brother | Son | Daughter | Aunt | Uncle | Grand-  mother | Grand-  father |
| Alcohol Abuse |  |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |  |  |
| COPD |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |
| Diabetes Mellitus |  |  |  |  |  |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  |  |  |  |  |  |
| Early Death |  |  |  |  |  |  |  |  |  |  |
| Hearing Loss |  |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |  |  |  |
| Learning Disability |  |  |  |  |  |  |  |  |  |  |
| Mental Health Disorder |  |  |  |  |  |  |  |  |  |  |
| Intellectual Disability |  |  |  |  |  |  |  |  |  |  |
| Miscarriage  Or Stillborn |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |
| Vision Loss |  |  |  |  |  |  |  |  |  |  |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_