BERKELEY FAMILY PRACTICE, LLC

Jeffrey Santi, MD • Jeremy Ackermann, DO • Sarah Heincelman, MD • Samuel Adams II, DO •
J. Dan Flaugher, MD • Margaret Sorrell, DO • Eric Lloyd, PA-C • Ashlyn Burns, PA-C •
Britton Tucker, PA-C • Jana Chinners, PA-C • Jacob Sooter, PA-C

New Patient Initial Visit Form

Name:_____ Date of Birth: _____ Age:_____ Date of Visit: _____
Previous Doctor Name and Phone Number: _____
Preferred Pharmacy Information: _____

PAST MEDICAL HISTORY

- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar Disease
- ☐ Blood Clots
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Seasonal Allergies
- ☐ Thyroid Disease
- ☐ Other: _____

CURRENT MEDICATIONS

☐ NONE

Name	Dosage	Frequency

ALLERGIES

☐ NO KNOWN DRUG ALLERGIES

_____
_____
_____

OBGYN HISTORY

☐ N/A

Last Menstrual Period: _____
Menopausal? ***Yes*** | ***No***
Total Number of Pregnancies: _____

SURGICAL PROCEDURES

☐ NONE

Date	Type

HOSPITALIZATIONS

☐ NONE

Date	Reason

FAMILY HISTORY

☐ UNKNOWN

Please list any medical problems of the following family members (see above) such high blood pressure, diabetes, heart disease, cancer, and more.

Father	Alive/Deceased	
Mother	Alive/Deceased	
Paternal Grandfather	Alive/Deceased	
Paternal Grandmother	Alive/Deceased	
Maternal Grandfather	Alive/Deceased	
Maternal Grandmother	Alive/Deceased	
Sibling(s)	Alive/Deceased	
Children	Alive/Deceased	

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SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widow / Widowerer
Occupation: _____
Do you live alone? **YES** or **NO** (If no, please indicate who lives with you: _____)
Do you feel safe at home? **YES** or **NO**
Do you have access to transportation? **YES** or **NO**
Do you have access to food? **YES** or **NO**

Over the past two weeks, how often have you been bothered by any of the following problems? (required)

PHQ-9 Depression Questionnaire*	Not at all (0)	Several days (1)	More than half of days (2)	Nearly every day (3)
Little interest or pleasure in doing things?				
Feeling down, depressed or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things such as reading the newspaper or watching TV?				
Moving or speaking so slowly that other people have noticed, or the opposite – being so fidgety or restless that you have been moving around more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				
Column Score *(Provider Use Only)*				
Total Score *(Provider Use Only)*				

Tobacco Use: Do you smoke cigarettes or use other tobacco products (vaping, chewing tobacco)? **YES** or **NO**

CURRENT SMOKERS:	FORMER SMOKERS:
How many years have you smoked? _____	When did you quit smoking? _____
How many packs per day? _____	How many years did you smoke? _____
	How many packs per day? _____

Drug Use: Any current or previous use of any drugs such as marijuana, cocaine, heroin, etc.? **YES** or **NO**

- If **YES,** what type of drug(s)? _____ Frequency: _____ How long: _____

Alcohol Use: Please fill out the questionnaire below. (required)

Audit-C Questionnaire*	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times Per month	2-3 times Per week	4+times Per week
How many drinks of alcohol do you have on a normal day?	None, **1-2**	3-4	5-6	7-9	10+
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily (or Almost)
Column Score *(Provider Use Only)*					
Total Score *(Provider Use Only)*					

* REQUIRED BY GOV. QUALITY METRIC SYSTEMS & ADVISED BY MOST INSURANCES

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____