# Barbara Ioannides Rappaport, MD, PA

New Patient Paperwork

NAME:_____ Birthdate _____

GENDER: _____

DATE: _____

ALLERGIES:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

Hypertension Diabetes:1 or 2 Elevated Cholesterol or Triglycerides Heart Attack/Heart Disease Congestive Heart Failure Kidney Disease Dialysis Bronchitis Pneumonia COPD Asthma Thyroid Disease Rheumatoid Arthritis Psoriasis Lupus Parkinson's Dementia Seasonal Allergies Depression Anxiety ADHD Substance Abuse Hepatitis A, B, C HIV Sleep Apnea Anemia B12 deficiency Seizures Stroke/TIA Neuropathy Vitamin D deficiency Irritable Bowel Syndrome Ulcerative Colitis Crohn's Disease Diverticulitis Arrhythmia (irregular heartbeat) DVT (Blood Clot) Liver Disease Osteoarthritis Migraines Headaches GERD (Acid Reflux) Hiatal Hernia Macular Degeneration Glaucoma Osteopenia/Osteoporosis Bladder Problems / Incontinence Kidney Stones/Kidney Disease Bleeding Problems Hiatal Hernia Peptic Ulcer Cancer: _____ Peripheral Vascular Disease Embolism (PE or DVT)

Other medical problems not listed above:

_____

_____

_____

_____

Women:

Last Menstrual Period Date: _____ Normal Abnormal

Colonoscopy Yes/No Date:_____ Normal Abnormal

Mammogram Yes/No Date:_____ Normal Abnormal

Dexa (Bone Density) Yes/No Date:_____ Normal Abnormal

Pap Yes/No Date:_____ Normal Abnormal

Men:

Colonoscopy Yes/No Date:_____ Normal Abnormal

PSA blood test Yes/No Date:_____Normal Abnormal

Surgical History: Please list all prior surgeries and approximate dates performed.

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Medical Issues: _____

MOTHER: Living: Age _____ Deceased: Age _____

Medical Issues: _____

SIBLINGS (include how many and any medical issues they might have):

_____
_____

_____

List other medical providers you see on a regular basis:

_____
_____

_____

Patient Signature: _____

Date: _____