Michael E. Elia, M.D.

WP HOSPITAL physician associates

369 White Plains Road
Eastchester, N.Y. 10709
914 337-3979

Patient Demographics

Patient's Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Gender F M

Address _____ Apt. # _____ City _____ State _____ Zip _____

Race:
☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone _____ Day Phone _____

Email Address _____ Cell Phone _____

Employer _____ Occupation _____ ☐Retired?

Employer Address _____

Emergency Contact _____/_____ Phone _____
Name Relationship

Primary Care Physician Name: _____ Phone:_____

Referring Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Primary Insurance Coverage: _____

Policy Holder Name: _____ SSN:_____ DOB:_____

Secondary Insurance Coverage: _____

Policy Holder Name: _____ SSN: _____ DOB: _____

This visit is covered by: ☐ No Fault Insurance ☐ Workers' Compensation _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature _____ Date_____
Responsible Party Name _____ Relationship _____

Patient History Form

Name: _____ **Date of Birth:** _____

Reason for Visit:

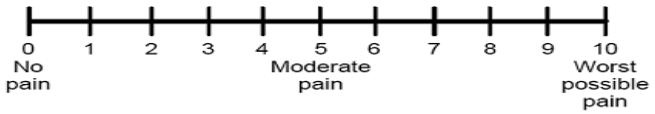
_____

_____

Please List All Current Medications			☐ **Not Currently Taking Any Medications**		
Medication Name	**Dosage**	**How Often Taking**	**Medication Name**	**Dosage**	**How Often Taking**
Vitamins/ Supplements	**Dosage**	**How Often Taking**	**Vitamins/ Supplements**		**How Often Taking**

Allergies (e.g. medication, latex, egg)		☐ **No Known Allergies**	
Allergen	Type of Reaction	Allergen	Type of Reaction

Please indicate (circle) your current pain scale in relation to your current condition:



How would you prefer that we contact you?

☐ Home Phone ☐ Cell Phone ☐ Work/Day Phone ☐ Patient Portal ☐ Home Address

☐ Other _____

Patient Signature: _____ Date: _____

Patient Representative Signature:_____ Relationship: _____

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NAME: _____ AGE: _____ DOB: _____ DATE: _____

Reason for today's visit: _____

MEDICAL CONDITIONS (circle all that apply):

Blood Pressure (High / Low)	Thyroid Disease	Diabetes
Stroke	Cholesterol	Heart Attack
HIV / AIDS	Hepatitis	

List any prior surgeries (please include the year of surgery)

_____

_____

_____

Have you ever had general anesthesia? NO YES
If YES were there problems? NO YES

FAMILY HISTORY

Member of Family	Alive	Deceased	Age	Health status or cause of death
Father	A	D	____	_____
Mother	A	D	____	_____
Sister (s)	A	D	____	_____
Brothers (s)	A	D	____	_____

Any other family illness that may be pertinent _____

SOCIAL HISTORY

History of Substance Abuse NO YES

I currently drink alcohol / beer Never Daily 1 – 2 x /wk 1 – 2 x /mo 1 – 2 x/yr

I smoke tobacco products NO YES I quit smoking _____
I currently smoke _____ packs / day for the past _____ years
Caffeine NO YES
Type Coffee Chocolate Energy Drinks Soda Tea Tablets
Amount Daily _____

Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: _____

Did the fall(s) result in injury? ☐ Yes ☐ No Do you use any assistive devices? ☐ Yes ☐ No

Have you recently felt physically or emotionally harmed? ☐ Yes ☐ No

_____ _____
PROVIDERS SIGNATURE DATE

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NAME: _____ DOB: _____

Allergies to Medications / Food ☐ None

_____

_____

Height: _____ Weight: _____

Dominate Hand (circle) Right Left Ambidextrous

Is it possible you are currently pregnant (circle)?: Yes No

REVIEW OF SYSTEMS:
Are you currently having or have you had problems with?:

	Circle		Describe all yes responses
Chills, Fever, Sweats	Y	N	_____
Weakness	Y	N	_____
Weight (gain/loss)	Y	N	_____
Eyes	Y	N	_____
Headaches	Y	N	_____
Ear problems/ Hearing	Y	N	_____ _____
Chest Pain	Y	N	_____
Bleeding problems	Y	N	_____
Cough	Y	N	_____
Asthma, COPD	Y	N	_____
Difficulty Breathing	Y	N	_____
Skin issues	Y	N	_____
Cancer	Y	N	_____
Heart Problems	Y	N	_____
Seizures /Tremors	Y	N	_____
Fainting / Blackout	Y	N	_____
Bleeding / Bruising	Y	N	_____
Urination Issues	Y	N	_____
Psychological Problems	Y	N	_____
Hot / Cold Intolerance	Y	N	_____
Difficulty walking	Y	N	_____
Numbness / Tingling	Y	N	_____
Liver Disease	Y	N	_____
Thyroid Disease	Y	N	_____
Arthritis / Gout	Y	N	_____
AIDS (may leave blank)	Y	N	_____
Hepatitis	Y	N	_____
Digestion Disorder	Y	N	_____

Above information was reviewed and any addition / changes to the form were noted.

_____ _____

PROVIDERS SIGNATURE DATE