Bernard Bernhardt, M.D. Elizabeth A. Phillips, M.D.



WPPA of Larchmont Hematology & Oncology 2345 Boston Post Road Larchmont, NY 10583

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 ☐ Black/African American		an/Pacific Islander	□ White □ Decline to Answer	
Ethnicity: ☐ Hispanic/Latino ☐ Not	Hispanic/Latino □	Decline to Answer Pr	eferred Language:	
Marital Status: ☐ Single ☐ Married	I □ Divorced □Wid	owed □Separated	Student Status □FT □	PT
Home Phone		Day Phone		
Email Address		CellPhone		
Employer		Occupation		□Retired?
Employer Address				
Emergency ContactName				
Primary CarePhysician Name:		·		
Referring Physician Name:				
Pharmacy Name:		Phone	e:	
Pharmacy Address:				
Primary Insurance Coverage:				
Policy Holder Name:				
Secondary Insurance Coverage:				
Policy Holder Name:		SSN:	DOB: _	
I certify this information is true and correauthorize the release of any medical informade to the physician unless my according to the physician unless my acco	ormation necessary to p	orocess an insurance cla		
Responsible Party Signature			Date	
Responsible Party Name			Relationship	

				Patien	t His	tory Form	• . 1 1			
	ne:					Date of B	irth: _			
кеа	son for Visit:									
Plea	se List All Current Med	ications			□Not	t Currently Tak	ing Ar	y Medication	ns	
Med	ication Name	Dosage	Hov	√ Often Ta	aking	Medication Name		Dosage	How Often Taking	
Alle	ergies (e.g. medication	on, late	x, e	gg)			□ No	Known All	ergies	
	rgen	•				Allergen			Type of Reaction	
				Past Mo	edic	al History				
	Anxiety Disorder			Divertio	culiti	S		Kidney Dise	ease	
	Arthritis			Fibromyalgia		a		Kidney Stones		
	Asthma			Gout				Leg/Foot Ulcers		
	Bleeding Disorder			Has Pacemaker			Liver Disease			
	Blood Clots (or DVT)			Heart Murmur			Osteoporosis			
	Coronary Artery Dise	ease		Hiatal Hernia			Polio			
	Claustrophobia			Reflux Disease			Pulmonary Embolism			
	Diabetes- insulin Diabetes- Non-insuli	in.		HIV or AIDs High Cholesterol		믐	Ulcers Stroke			
H	Dialysis	111	片	High Blood Pre			붐	Tuberculosis		
	DVT						╁	Other		
-										
Cancer History										
Cancer Type Year D			r Dia	gnosed	-	Treatment (e.g.	chem	no, radiation)	Year Treated	

Please list all past surgical procedures:	Patient Name:	atient Name:Date of Birth:						
Surgical Procedure Year Surgeon	Past Surg	ical History						
Surgical Procedure Surgeon Surgeon		,	□ No Surgical History					
Social History Smoking Status: Smoking Tobacco Use History (all patients age 13 and older): Never Smoker Current Every Day Smoker Current Smoker Smoking Tobacco Use History (all patients age 13 and older): Never Smoker Current Swome Day Smoker Smoker Smoker Smoker Current Status Unknown Alcohol & Caffeine Use: Do You Consume Alcohol? No Yes Former Frequency: Amount: Caffeine per day: Fall Risk: Haveyou 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 Pain Scale: Please indicate (circle) your current pain scale in relation to your current condition: No No Moderate pain Patient Signature: Date:		Year	<u> </u>					
Smoking Tobacco Use History (all patients age 13 and older): Never Smoker	Jul Sicurit recount							
Smoking Tobacco Use History (all patients age 13 and older): If there is a history of tobacco use: Never Smoker Current Every Day Smoker Years Used: Years Used: Usage Per Day: Alcohol & Caffeine Use: Do You Consume Alcohol? No Yes Former Frequency: Amount: Patient Signature: Do You Consume Caffeine? No Yes Type: Caffeine per day: The patient Signature: Do You Consume Caffeine? No Yes No The patient Signature: Do You Consume Caffeine? No Yes No The patient Signature: Do You Consume Caffeine? No Yes No No No No Moderate Moderate Mossible Do You Consume Caffeine? No Yes No No No Moderate Do You Consume Caffeine? No Yes No No No Moderate Do You Consume Caffeine? No Yes No No No No Moderate Do You Consume Caffeine? No No No Moderate Do You Consume Caffeine? No No No Moderate No No No No Moderate Do You Consume Caffeine? Do You Consume Caffeine? No No No No No Moderate No No No No No No No N								
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Smoking Tobacco Use History (all patients age 13 and older): Never Smoker								
Smoking Tobacco Use History (all patients age 13 and older): Never Smoker	Social	History						
□ Never Smoker □ Current Every Day Smoker □ Current Smoker □ Current Some Day Smoker □ Smoker □ Current Some Day Smoker □ Smoker	Smoking Status:							
□ Former Smoker □ Current Some Day Smoker Age Stopped: □ Smoker Current Status Unknown if Ever Smoker □ Smoker Current Status Unknown Age Stopped: □ Stopped: □ Smoker Current Status Unknown Age Stopped: □ Stopped:								
□ Unknown if Ever Smoker □ Smoker Current Status Unknown Age Stopped:			Years Used:					
Alcohol & Caffeine Use: Do You Consume Alcohol?			Age Stopped:					
Do You Consume Alcohol?		it Status Unknown	де жереч					
Do You Consume Caffeine? No Yes Type:								
Fall Risk: Haveyou 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 Pain Scale: Please indicate (circle) your current pain scale in relation to your current condition: \[\begin{align*} \text{Pain Scale:} \\ \text{Please indicate (circle) your current pain scale in relation to your current condition:} \[\begin{align*} \text{No Moderate Worst pain possible pain} \] Patient Signature:								
Haveyouhadany falls in the last year?	Do You Consume Caffeine? □ No □ Yes Type:Caffeine per day:							
Haveyouhadany falls in the last year?	Fall Risk:							
Pain Scale: Please indicate (circle) your current pain scale in relation to your current condition: O 1 2 3 4 5 6 7 8 9 10 No Moderate Worst pain pain possible pain Patient Signature: Date:		Yes, please state th	ne number of falls:					
Pain Scale: Please indicate (circle) your current pain scale in relation to your current condition: 0 1 2 3 4 5 6 7 8 9 10 No Moderate Worst pain possible pain Patient Signature: Date:								
Please indicate (circle) your current pain scale in relation to your current condition:	Did the fall(s) result in injury? ☐ Yes ☐ No							
Please indicate (circle) your current pain scale in relation to your current condition:								
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No Moderate Worst possible pain Patient Signature:	0 1 2 3 4 5 6	7 8 9	10					
Patient Signature:Date:								
Patient Signature:Date:	pain pain	pos	ssible					
		p	pain					
	Dationt Signatura:		Date					
Patient Representative Signature: Relationship:	ratient signature:		Date:					
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