Adolescent Healthcare Center: New Patient Form

One Hoppin St., Coro West Suite 3055, Providence, RI 02903	Phone: 401-444-5980	Fax: 401-444-3873

Please complete this form before your first appointment, and bring it with you

Patient Information

Legal Name:	Preferred Name (if different):
Gender:	Preferred Pronouns:
Date of Birth:	Age:
Permanent Address:	
Home phone:	
Cell Phone:	
Email address:	
Preferred method of communication (circle): home phone cell phone e-mail	

Parent/Guardian Contact Information

Name
Address (check ___ if same as above)
Home phone:
Cell Phone:
Email address:
Preferred method of communication (circle first choice): home phone cell phone e-mail
Name:
Address (check ___ if same as above)
Home phone:
Cell Phone:
Email address:
Preferred method of communication (circle first choice): home phone cell phone e-mail

Patient Medical History

	No	Yes (please specify details)
Allergies		
Overnight in a hospital		
Surgery		
Problems with birth		
Problems with early development		
Any delayed/missing vaccines?		

Please list any prescriptions, over-the-counter medications, or supplements you are taking:

Medication/supplement name	Dose	How often do you take it

Please check whether the patient has had any of these problems and age when they occurred:

	At this time	In the last 6 months	Ever in the past (age)
Scoliosis			
Arthritis			
Muscle/joint pain or swelling			
Broken bones			
Easy bruising/bleeding			
Anemia or Blood disorder			
Cancer			
Dizziness/blackouts/fainting			
Seizures			
Headaches			
Weakness, feeling tired			
Heart disease			
Asthma/other breathing problem			
Hay fever/environmental allergy			
Chest pain or racing heart			
Dry skin			
Nausea/Vomiting			
Diarrhea			
Constipation			
Abdominal pain			
Liver disease			
Problems with urination ("peeing")			
Diabetes			
Thyroid problem			
Irregular, painful, or heavy periods			
Poor sleep			
Mental Health/Behavior Problems			
Other:			

Family History (place an "X" in the appropriate box)

	Father	Mother	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother	Sibling Brother (B) Sister (S)
Asthma							
Anemia							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Headaches							
Thyroid Disease							

Family History Continued	Father	Mother	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother	Sibling Brother (B) Sister (S)
Weight problems (over or under-weight)							
Mental Health Issues							
Suicide							
Substance abuse							
Sudden death							
Other							

Other Provider Information

Most Recent Pediatrician/Primary Care Provider Name:
Address
Phone
Dentist Name:
Address
Phone
Eye Doctor Name:
Address
Phone
Therapist Name:
Address
Phone
Psychiatrist Name:
Address
Phone
Dietitian Name:
Address
Phone
Other Specialist Name:
Address
Phone

If you have not already done so, please ask your providers to send any vaccine records, growth charts, recent labs, and office notes to us <u>before</u> your appointment at:

Adolescent Medicine Clinic
One Hoppin Street
Coro West, Suite 3055
Providence, RI 20903

Fax: 401-444-3873
Phone: 401-444-5980