Dr. Rudy V. Byron
6232 Bankers Road
Lower Level
Racine, WI 53403

Welcome To Our Office!

Name: _____ Today's Date: _____/_____/_____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address: _____ May we contact you here? (circle) YES / NO

Birthdate: _____/_____/_____ Age: _____ SSN: _____-_____-_____

Employer: _____ May we contact you at work? (circle) YES / NO

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: ( ) _____-_____ Years employed: _____ Occupation: _____

Name of Spouse: _____

Birthdate: _____/_____/_____ Age: _____ SSN: _____-_____-_____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address: _____ May we contact you here? (circle) YES / NO

Birthdate: _____/_____/_____ Age: _____ SSN: _____-_____-_____

Employer: _____ May we contact you at work? (circle) YES / NO

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: ( ) _____-_____ Years employed: _____ Occupation: _____

How did you hear about Byron Health & Healing? _____

Do you wish correspondence to be confidential? (circle) YES / NO Do you wish phone calls to be confidential? (circle) YES / NO

Family Practice New Patient Intake Form

Reason for Visit: _____

Past Medical History:

Please review the list below and check any problems you have had now or in the past:

Abnormal Pap Smear	
Acne	
ADD / ADHD	
Alcohol abuse	
Anemia	
Anxiety Disorder	
Asthma	
Bipolar Disorder	
Blood Clot	
Blood Transfusion	
Cancer (What kind?)	
Chronic Bronchitis	
Crohn's Disease or IBS	
Colon Polyps	
Depression	
Diabetes	
Diverticulitis	
Drug Abuse	
Eating Disorder	

Eczema	
Emphysema	
Frequent UTI's	
Frequent Sinus Infections	
Gallstones	
Glaucoma	
Gout	
Heart Attack	
Heart Condition (specify)	
Hepatitis (specify A,B,C)	
High Blood Pressure	
High Cholesterol	
Kidney Disease	
Kidney Infections	
Kidney Stones	
Lupus	
Melanoma or Skin Cancer	
Migraines	
Osteoarthritis	

Osteopenia	
Osteoporosis	
Positive TB Skin Test	
Prostate Problems	
Psoriasis	
Reflux (heartburn)	
Rheumatoid Arthritis	
Rosacea	
Seasonal Allergies	
Seizures	
Sexually Transmitted Disease (specify)	
Stomach Ulcers	
Stroke	
Tuberculosis	
Thyroid Disease	
Ulcerative Colitis	
Warts	

Other medical problem not on list: _____

Please check or list all of the **SURGERIES** you have had:

	Type of Surgery	Year
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of Surgery	Year
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/ Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	
	Other (specify)	

Current Medications: (Please include over the counter medications and food supplements.)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes / No**

Drug Name:	Reaction:

NAME: _____

For Women:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	Y N
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family member:
	Heart Disease / Attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer (specify)	

Any other illness in the family not listed? _____

Social History:

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Highest Level of Education: ☐ 6th grade ☐ Jr. High ☐ High School ☐ College

☐ Graduate School ☐ Professional

Occupation: _____

If you have children, please list their names and ages:

_____

Health Habits:

1. Do you currently smoke? ☐ Yes ☐ No If so, how much? ____ cig/day
   # of years smoking ____

   If no, did you smoke in the past? ☐ Yes ☐ No How many years? ____

   How much? ___ pk/day

   Quit date _____

   Are you exposed to smoke? ☐ Yes ☐ No

   Any other tobacco use? ☐ Yes ☐ No Type: ☐ Cigars ☐ Chewing tobacco
   ☐ Snuff ☐ Other

2. Do you drink caffeine? ☐ Yes ☐ No If so, how much? _____
3. Do you drink Alcohol? ☐ Yes ☐ No What kind? ☐ Beer ☐ Wine ☐ Liquor
   ☐ Other _____

   If so, how many times?
   ____ week ____ month ____ year

   Have you ever had a problem with alcohol in the past? (legal or social)

   _____

4. Have you ever used street drugs? ☐ Yes ☐ No

   Which ones? ☐ Marijuana ☐ IV drugs ☐ Amphetamines ☐ Cocaine ☐ Heroin
   ☐ Downers ☐ Inhalants ☐ Other _____

   Are you still using? ☐ Yes ☐ No
5. Are you sexually active? (in the last year) ☐ Yes ☐ No

   If yes, check all that apply ☐ 1 partner ☐ multiple partners
   ☐ Male partner(s) ☐ Female partner(s)

   Which birth control do you or your partner use? ☐ None ☐ Condoms ☐ The Pill
   ☐ Vasectomy / Tubal ☐ Other _____
6. Do you exercise? ☐ Yes ☐ No If so, what type and how often? _____
7. Do you eat out at restaurants weekly? ☐ Yes ☐ No Times per week _____
8. How many servings of fruits and vegetables do you get per day? 0 1 2 3 4 5 more than 5
9. Do you take a calcium supplement? ☐ Yes ☐ No Number of dairy servings per day: _____
10. Do you wear a seatbelt? ☐ Yes ☐ No
11. Do you have a living will? (do not resuscitate, medical power of attorney) ☐ Yes ☐ No Please ask for info.
12. Is there concern for your safety? (emotional, physical, or sexual abuse) ☐ Yes ☐ No

NAME: _____

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Lower Level
Racine, WI 53403

Insurance Information

Name: _____ Today's Date: _____
First Middle Last

Primary Insurance

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____

Secondary Insurance

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____