LEHIGH FAMILY HEALTH CENTER
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ALLENTOWN PA 18104
FAX 484-403-4005 WEBSITE www.matlv.com

Twinkle Nagpal, MD
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(610) 871-2800

NEW PATIENT INFORMATION

PATIENT INFORMATION DATE: _____

Name _____

Date of Birth _____ Gender _____ Race _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Day Phone _____ Cell Phone _____

Last 4 digits of Social Security # _____ Marital Status M S W D Email _____

Name of Emergency Contact _____

Emergency Contact Phone # _____ Relationship _____

May we leave a message on your voicemail? Yes No

May we speak to another person regarding your condition? Yes No

Name of Person _____ Phone number _____

Name of Person _____ Phone number _____

ALLEGIES TO MEDICATIONS _____

_____

_____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Phone # _____

Address _____ Occupation _____

Patient Name _____
Date of Birth _____

FAMILY HISTORY

Please list any family member which have been affected by the following illnesses:

	FAMILY MEMBER
Cancer (what type?)	_____
Diabetes	_____
Heart Disease	_____
Heart Attack	_____
Stroke	_____
Seizures	_____
Dementia	_____
Hypertension	_____

SOCIAL HISTORY

Marital Status M D W S
Children? Y N Boys _____ Girls _____
Do you live alone? ____ If not, who lives with you? _____
Do you consume caffeine? Y N Coffee Tea Soda Chocolate
Amount daily? _____
Do you smoke? Y N Number of packs per day _____
Do you drink alcohol? Y N What type _____ How often _____
What is/was your occupation? _____
Employment Status: full time part time retired unemployed
Do you exercise? Y N Type? _____ Frequency _____
Do you wear seatbelts? Y N
Do you have a smoke detector in your home? Y N Carbon monoxide detector? Y N
Are there firearms in your home? Y N
Has your home been tested for Radon? Y N Positive Negative Treated? Y N
What type of home heating do you have? _____

ADVANCED DIRECTIVES

None Living Will Durable Power of Attorney HC proxy

Patient Name_____
Date of birth _____

PHARMACY

What Pharmacy do you use?
Local: _____Address_____Phone:_____
Mail away:_____Address:_____

ALLERGIES:_____

MEDICATIONS

_____
_____
_____
_____
_____
_____

PAST MEDICAL/SURGICAL HISTORY

List any surgeries you have had in the past: Name of Surgeon

_____ _____
_____ _____
_____ _____
_____ _____

List name of any other specialists (including eye doctor and dentist) you see and for what condition:
_____
_____
_____
_____
_____

When was your last:

Shingles shot _____
Tetanus shot _____
Flu Shot _____
Pneumonia _____
Mammogram_____
GYN visit _____
Colonoscopy _____
PSA_____

How often do you see:

Dentist_____
Eye Doctor_____