Internal Medicine
Associates of the Grand Valley
Community HOSPITAL

New Patient Health Questionnaire

Date: _____

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

Address: _____

City: _____ **State:** _____ **Zipcode:** _____

Primary Phone Number: _____

Preferred Doctor at IMA: _____ **Referred By:** _____

Is this a consult for another physician? Yes No Name of Physician: _____

Primary Insurance: _____ **Secondary:** _____

How soon do you need to be seen? _____ Medical Concern: _____

Are you related to an established patient? Yes No Name of relative: _____

Have you seen our physicians before? Yes No Physician Name: _____

Have you seen a physician in the last year? Yes No Physician Name: _____

Current Medications (including dosage):

_____

_____

Please circle the following medical conditions you have:

Diabetes Heart Condition Arthritis Breathing Problems Thyroid Condition

Hypertension High Cholesterol

Do you experience chronic pain? Yes No Where: _____

Other Health Concerns: _____

Office Use Only

Physician Initials: _____