Miriam Schultz, M.D. 5665 College Avenue, Suite 340 D, Oakland, CA 94618

NEW PATIENT INFORMATION

Date:_____

NAME: First:_____ M.I.:_____ Last:_____

DOB:_____ SS#:_____ Marital Status: S / M / D / W

Address:_____

City:_____State:_____Zip:_____

Email address:_____ OK to use? Yes No

OK to leave messages?

Home Tel:_____ Yes No

Work Tel:_____ Yes No

Cell: _____ Yes No

Please place a check next to the phone number above you'd most prefer me to use as primary mode of contact.

Occupation:_____ Hours worked per week:_____

Employer (name of school if student):_____

Health Insurance:

Do you have health insurance? **Y / N**

Medicare? **Y / N** Medicaid? **Y / N**

Other? **Y / N** (if Yes, Name of Provider: _____)

Prescription coverage? **Y / N**

Emergency Contact Info: *(please provide at least two methods of contact including one telephone number)*

Name:_____ Relationship:_____

Address:_____ Home Tel:_____

_____ Cell:_____

Email Address:_____ Work Tel:_____

How did you hear about my services? _____

What is your reason for making an appointment? _____

MEDICAL HISTORY
(Part 1)

Name: _____ Date: _____

PRIMARY CARE PROVIDER: I do not have a primary care provider ☐

Name: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Fax: _____

Date of last visit: _____ Frequency of visits: _____

PSYCHOLOGIST OR THERAPIST: I do not have a therapist ☐

Name: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____ Fax: _____

Date of last visit: _____ Frequency of visits: _____

CURRENT/FORMER PSYCHIATRIST: I have never had a psychiatrist ☐

Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

Date of last visit: _____ Frequency of visits: _____

This information is for my records only and any communication with the above named providers will only occur with your signed authorization.

MEDICAL HISTORY
(Part 2)

CURRENT MEDICATIONS: *Including OTC (over-the-counter) drugs, herbal remedies, and nutritional supplements, both daily and occasional use:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES *(to medications or foods):*

_____

_____

_____

SPECIALISTS SEEN: *(at any point in the past)*

__Allergist
__Endocrinologist
__Gastroenterologist
__Hematologist
__Infectious disease specialist
__Nephrologist
__Dermatologist
__Cardiologist
__Neurologist
__Sleep specialist
__Neurosurgeon
__Cardiologist
__Cardiothoracic surgeon
__General surgeon

__OTHER_____
__NONE OF THE ABOVE

__Plastic surgeon
__Pain specialist
__Orthopedic surgeon
__ENT specialist (ear/nose/throat)
__Urologist
__Rheumatologist
__Oral surgeon
__Pulmonologist
__Oncologist

OTHER THAN ROUTINE:
__OB/GYN
__Ophthalmologist
__Internist

MEDICAL CONDITIONS: *(please list all medical conditions that you have been evaluated for, diagnosed with, and/or treated for, both current and past):*

_____

_____

_____

_____

_____

_____

HOSPITALIZATIONS, SURGERIES, & EMERGENCY ROOM VISITS:

_____

_____

_____

_____

_____

_____

Have you ever had:

__Seizures
__Blackouts
__Fainting spells
__Heart palpitations
__Chest pain
__Shortness of breath/asthma
__Fracture or severe injury
__Head injury/concussion
__NONE OF THE ABOVE

Please print this form, complete it and **bring it to your first visit.**
By completing this form to the best of your abilities, we will be able to spend more time during the first session discussing your case. Thank you.