Gina Greco-Tartaglia, MD, PC, FAAFP
225 Veterans Rd.
Yorktown Heights, NY 10598

Last Name_____ First Name_____ MI_____

Date of Birth_____ Marital Status: M/ S/ W/ D/ Other_____

Address_____

City_____ State_____ Zip_____

Home #_____ Work #_____ Cell #_____

SS#_____ Email_____

Place of Employment/Occupation_____

Emergency Contact_____ Relation_____ Phone #_____

_____

Primary Insurance_____

Policy Holder_____ SS #_____ DOB_____

Subscriber's ID #_____ Group # _____

Relation to Patient: Self/ Spouse/ Child/ Other_____

_____

Secondary Insurance_____

Policy Holder_____ SS #_____ DOB_____

Subscriber's ID #_____ Group #_____

Relation to Patient: Self/ Spouse/ Child/ Other_____

_____

I certify that the above information is correct to the best of my knowledge. I, the undersigned, certify that I have insurance coverage with _____ and assign directly to Dr. Tartaglia all insurance benefits. I further understand that I will be responsible for any charges not covered by my insurance company. I also understand that a fee of $80.00 will be charged to me for any appointment canceled without 24 hours notice. I also authorize release of any medical information to my insurance company. I also certify that I have read and have been given a copy of the Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

X_____ Date_____

Gina Greco-Tartaglia, MD, PC, FAAFP

PATIENT INTAKE AND HISTORY FORM

(Please print)

Date: _____

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

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ More Than One Race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused to Report/Unreported

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported

Language: ☐ English ☐ Spanish ☐ Other: _____

Local Pharmacy: _____
(Name/City/Phone #)

Mail Order Pharmacy: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Timing/Onset: When did symptoms first occur? _____

Duration: Frequency of symptoms? _____

Characterized as/Severity: Describe the severity of the symptoms/pain. _____

Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _____

_____

Modifying Factors: What makes the condition better and/or worse? _____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ ADD	___ Bleeding Disorder	___ Diabetes	___ Hereditary Disease	___ Seasonal Allergies
___ ADHD	___ Cancer	___ Gallbladder Problem	___ High Blood Pressure	___ Seizures
___ Anxiety	___ Chronic Hepatitis	___ GERD	___ High Cholesterol	___ STD
___ Arthritis	___ Crohn's Disease	___ Gout	___ Irritable Bowel Syn.	
___ Asthma	___ Depression	___ Heart Disease	___ Pancreatitis	

___ Other: _____

MEDICATION HISTORY:

☐ I am not currently taking any medications ☐ No change since last visit

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	Name of Medication	Dosage

ALLERGY HISTORY:

☐ None ☐ NKDA (No Known Drug Allergies)

___ Acetaminophen	___ Epinephrine	___ Latex	___ Penicillin
___ Aspirin	___ Erythromycin	___ Lidocaine	___ Sulfur
___ Codeine	___ Ibuprofen	___ Metal	___ Tetracycline

Other: _____

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Aneurysm						
Arrhythmia						
Bleeding Disorder						
Cancer (type)						
Cardiomyopathy						
Cirrhosis of Liver						
Congenital Heart Defect						
Crohn's Disease						
Deafness						
Diabetes						
Enlarged Heart						
Esophageal Reflux						
Gout						
Heart Attack < age 50						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Irregular Heart Beats						
Irritable Bowel Syndrome						
Lupus						
Marfans						
Mitral Valve Prolapse						
Pacemaker						
Prolonged QT Syndrome						
Stillbirths						
Stroke						
Seizure Disorder						
SIDS						
Sudden/Accidental Death						
Syncope/Passing Out						
Tachycardia						
Valve Leak/Narrowing						

Other: _____

_____

PAST SURGICAL HISTORY:

(New patients and/or since last visit)

___ Appendix
___ Cataract Surgery
___ Cosmetic Surgery
___ Gallbladder Surgery
___ Heart Bypass
___ Heart Valve Surgery
___ Hysterectomy with ovaries
___ Hysterectomy without ovaries
___ Joint Replacement - Hip
___ Joint Replacement – Knee
___ Joint Replacement – Shoulder
___ Tonsils +/- Adenoids

List significant surgeries or injuries (Write "None" if you have no past surgeries or injuries):

Surgeries/Injuries — *Date(s) or Age/Surgeon*

_____

_____

_____

_____

SOCIAL HISTORY:

Please describe your Current Household Members? Mother___ Father___ Sibling(s)___ Significant Other___

Please describe your Current School Status? ☐ Regular school ☐ Special education ☐ Full-time ☐ Part-time

Please describe your Current Tobacco Use?

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Current everyday smoker
☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day: _____

Do you drink caffeinated beverages? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐Yes ☐No
If yes, please indicate what type of drug and how often: _____

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Heavy

BIRTH HISTORY: (New patients under 18 years old)

Please describe the patient's:
Gestational age: ☐ Pre-term (how many weeks) _____ ☐ Term ☐ Post-term
Delivery mode: ☐ Vaginal delivery ☐ C-Section
Birth weight: _____
Hospital stay: ☐ Home on day 2 ☐ Home on day 4 ☐ Routine newborn care ☐ Neonatal ICU
☐ Other: _____
Pregnancy complications: ☐ None ☐ Other: _____
Delivery complications: ☐ None ☐ Other: _____

VITALS: Height: _____ Weight: _____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Dietary Changes
- ☐ Significant Weight Change

Skin:
- ☐ Acne
- ☐ Bruising
- ☐ Dryness
- ☐ Excessive Sweating
- ☐ Hair Loss
- ☐ Itching
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT:
- ☐ Blurred Vision
- ☐ Eye Redness
- ☐ Headache
- ☐ Hearing Loss
- ☐ Seasonal Allergies

Neck:
- ☐ Neck Mass
- ☐ Swollen Glands

Respiratory:
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Wheezing

Breast:
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Breast Swelling
- ☐ Skin Changes

Cardiovascular:
- ☐ Heart Stent
- ☐ High Blood Pressure
- ☐ Leg Pain and/or Swelling

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Incontinence
- ☐ Painful Urination

Musculoskeletal:
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Swelling of Extremities

Neurological:
- ☐ Fainting
- ☐ Dizziness
- ☐ Loss of Consciousness
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Easily Irritated
- ☐ Memory Loss

Endocrine/Glands:
- ☐ Appetite Changes
- ☐ Thyroid Problems

Hematology:
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Enlarged Lymph Nodes

HISTORY & PHYSICAL

DATE

NAME | M F | MARITAL STATUS S M W D SEP | DATE OF BIRTH

Formedic

ADDRESS | PHONE (H) | (O)

OCCUPATION/ EMPLOYER | INSURANCE

PAGE #

CHART #

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Hay fever	11) Arthritis	16) Cancer
2) Migraine	7) Asthma	12) Heart disease	17) Restless leg syndrome
3) Glaucoma	8) Anemia	13) Stroke	18) Depression
4) Diabetes	9) Bleeding disorder	14) Hypertension	19) Alcoholism
5) Thyroid disease	10) Osteoporosis	15) Lipid disorder	20) Mental illness

HOSPITAL ADMISSIONS *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

SUPPLEMENTS

VACCINE — YEAR OF LAST

- Tetanus / Td ____
- Influenza (flu) ____
- Pneumonia ____
- Hepatitis A ____
- Hepatitis B ____
- Whooping C ____

VACCINE — YEAR OF LAST

- MMR (Measles, Mumps, Rubella) ____
- Meningitis ____
- Chicken pox ____
- HPV ____
- Shingles ____

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM _____

- ☐ Hearing problems ☐ Ringing in ear
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Vision problems ☐ Eye pain
  Date of last eye exam _____
- ☐ Nose bleeds ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
  Date of last TB test _____
- ☐ Shortness of breath:
  ☐ on exertion ☐ lying flat
  ☐ in the past week
  ☐ affects work lifestyle
- ☐ Chest pain ☐ High blood pressure
  Date of last cholesterol test _____
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain ☐ Cold numb feet
- ☐ Varicose veins / Phlebitis
- ☐ Appetite ☐ Difficulty swallowing
  ☐ loss ☐ gain

- ☐ Heartburn ☐ Peptic ulcer
- ☐ Aspirin - arthritis - pain pills
- ☐ Nausea / vomiting ☐ Gallbladder dis
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Test for blood in stool
- ☐ Hemorrhoids ☐ Hernia

Urination - Overactive bladder
- ☐ Overnight > than twice
- ☐ More than 8 times / 24 hrs.
- ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections ☐ Prostate prob
- ☐ Bed wetting
- ☐ Weight-loss ☐ gain
- ☐ Anemia ☐ Bruise easily
- ☐ Cancer ☐ Fatigue / loss of energy
- ☐ Diabetes ☐ Thyroid disease

- ☐ Arthritis / Rheumatism ☐ Back pain
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Excessive sweating
- ☐ Seizures ☐ Stroke
- ☐ Tremor/hands ☐ Numbness
- ☐ Headaches ☐ Memory loss
- ☐ Depression ☐ Confusion
- ☐ Decreased work performance
- ☐ Sleep problems
  for how long ____ how often ____
  sleeping - ☐ too little ☐ too much
  waking refreshed ☐ yes ☐ no
  ☐ Legs keep you up at night
- ☐ Concentration problems
- ☐ Difficulty with unfamiliar tasks
- ☐ Thoughts of death ☐ suicide
- ☐ Anxiety ☐ Mood swings ☐ Phobias
- ☐ Mental illness
- ☐ Sexual problems / enjoyment
- ☐ Rheumatic fever ☐ Measles
  ☐ Chicken pox ☐ Polio ☐ Mumps

- ☐ Tuberculosis ☐ German measles
- ☐ Herpes ☐ Aids / HIV
- ☐ Sexually transmitted diseases - # of encounters ____
- ☐ Alcohol _____ oz. per week
- ☐ Coffee / Tea _____ cups per day
- ☐ Smoking- cig/day ____ # years
  year quit ____
- ☐ Exercise _____
- ☐ Street drugs _____
- ☐ Travel abroad _____

FEMALES - *Please complete*

Menstrual flow:
☐ Reg. ☐ Irreg. ☐ Pain / Cramps
Days of flow ____ Length of cycle ____
Date -1st day of last period _____

☐ Pain / Bleeding during or after sex

Number of:
Pregnancies ____ Abortions ____
Miscarriages ____ Live births ____

Birth control method _____

☐ Flushing / Menopause

Date of last PAP test _____
☐ Normal ☐ Abnormal

Date of last mammogram
☐ Normal ☐ Abnormal

SYNOPSIS