Trenton Total Health Care Center
A patient-centric Care Provider

NEW PATIENT FORM

PATIENT INFORMATION				
Date of Visit	First Name	Last Name		
Home Address				
Gender (check one)		Date of Birth	Social Security #	
☐ Male ☐ Transgender ☐ Female ☐ Decline to answer				
Marital Status (check one)		Spouse's Full Name		
☐ Single ☐ Married ☐ Divorced ☐ Widowed				
Mobile #	Home #	Work #	E-mail address	
Emergency Contact Name		Relationship	Emergency Contact Phone #	
Language Spoken at Home				
☐ English ☐ Spanish ☐ German ☐ French ☐ Russian ☐ Hindi/Urdu ☐ Arabic ☐ Chinese ☐ Japanese ☐ Other				
Race & Ethnicity (check one)				
☐ White / Caucasian ☐ Latino/Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Black / African American ☐ Asian ☐ American Indian/ Alaskan Native ☐ Other				

INSURANCE INFORMATION		
	Primary Insurance	Secondary Insurance
Type of Insurance		
Subscriber		
Subscriber DOB (if not patient)		
Policy Number		
Group Number		

PHYSICIAN (S) & PHARMACY INFORMATION		
	Name	Phone #
Referring Physician		
Primary Care Physician		
Pharmacy		
Other Physicians		

1675 Kingsway Ct. Trenton, MI 48183
Phone: 734-676-8530 | Fax: 734-676-2319 | e-mail: contact@tthcpc.com | website: www.tthcpc.com

NEW PATIENT FORM

REVIEW OF SYMPTOMS (Check all that applies)

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Short of Breath on Exertion
- ☐ Congestion
- ☐ Cough

CARDIOLOGY
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Sweating
- ☐ Swelling
- ☐ Fluttering Sensation

GENERAL
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Fevers
- ☐ Weakness
- ☐ Fatigue

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Increased Thirst

FEMALE REPRODUCTIVE
- ☐ Pregnant
- ☐ Menopause

MALE REPRODUCTIVE
- ☐ Difficulty with Erection

OPTHOMOLOGY
- ☐ Diminished Vision
- ☐ Blurring of Vision
- ☐ Loss of Vision
- ☐ Vision Floaters

GASTROENTEROLOGY
- ☐ Nausea
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Indigestion
- ☐ Abdominal Pain

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Bleeding

PSYCHOLOGY
- ☐ Depression
- ☐ Anxiety
- ☐ High Stress

NEUROLOGY
- ☐ Headaches
- ☐ Tingling
- ☐ Fainting
- ☐ Dizziness
- ☐ Difficulty Walking
- ☐ Memory Loss

DERMOTOLOGY
- ☐ Rash
- ☐ Flushing
- ☐ Wound
- ☐ Dry skin

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Leg Cramps
- ☐ Back Pain
- ☐ Arm Pain
- ☐ Neck Pain
- ☐ Leg Pain
- ☐ Muscle Pain

HABITS

Do you Smoke?	Yes	No	If smoke, how long?	If smoke, packs daily:	If quit, when?
Do you drink Coffee?	Yes	No	If coffee, how many cups daily?	Other Caffeine	
Do you drink Alcohol?	Yes	No	Type:	Amount:	Frequency:
Sleeping Habits	☐ Snoring ☐ Daytime Drowsiness ☐ Difficulty Falling Asleep ☐ Continuity Disturbances ☐ Early Morning Awakening ☐ Other _____				
Do you exercise?	Yes	No	If Yes, type of exercises:		
Used illegal drugs?	Yes	No	If Yes, what drugs:		

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NEW PATIENT FORM

NEW PATIENT MEDICAL HISTORY (Check all that applies)

☐ Asthma	☐ Gallstone	☐ Stroke
☐ Angina/Chest Pain	☐ Heart Attack	☐ Thrombophlebitis
☐ Anemia	☐ Heart Murmur	☐ Thyroid Disease
☐ Arthritis	☐ Headaches	☐ Tuberculosis
☐ Glaucoma	☐ High Blood Pressure	☐ Ulcers
☐ Chronic Bronchitis	☐ High Cholesterol	☐ Other – Please list below
☐ Cirrhosis	☐ HIV positive/AIDS	
☐ Clotting Disorder	☐ Kidney Disease	_____
☐ Emphysema	☐ Kidney Stones	_____
☐ Epilepsy	☐ Positive TB Test	_____
☐ Fractures	☐ Rheumatic Fever	_____
		_____

FAMILY HISTORY

If any blood relative has ever had any of the following, please check and indicate relationship

CONDITION	RELATIONSHIP
☐ Bleeding Tendency	_____
☐ Cancer	_____
☐ Diabetes	_____
☐ Heart Attack	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ Kidney Disease	_____
☐ Liver Disease	_____
☐ Migraine Headache	_____
☐ Stroke	_____
☐ Tuberculosis	_____

Please indicate the age & either Living or Dead for each of the following:

Father:	Age: _____	☐ Living	☐ Dead
Mother:	Age: _____	☐ Living	☐ Dead
Siblings:	Age: _____	☐ Living	☐ Dead
	Age: _____	☐ Living	☐ Dead
	Age: _____	☐ Living	☐ Dead
	Age: _____	☐ Living	☐ Dead
	Age: _____	☐ Living	☐ Dead

OPERATIONS and/or HOSPITALIZATIONS (List below with approximate date)

REASON	DATE	REASON	DATE

ALLERGIES to MEDICATIONS (List below any allergies to medications)

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