Aegis Medical Center
A Division of Rao Clinic

NEW PATIENT PAPERWORK

1000 Crescent Green
Suite 102
Cary, NC 27518
Telephone: 919-233-0410
Fax: 919-233-0872

Name:	DOB:
Sex: ☐ Female ☐ Male ☐ Other	Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other
Email:	Social Security#:
Street Address:	
City:	State: Zip Code:
Home Phone:	Cell Phone:
Preferred Contact: ☐ Phone ☐ Text ☐ Email	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Emergency Contact Name:	
Relationship:	Contact Number:

Insurance

Primary Insurance:	
Member Id:	Group#:
Policy Holder Name:	DOB:
Relationship To Patient:	
Secondary Insurance:	
Member ID:	Group#:
Address:	
Phone:	Fax:

ALLERGIES ☐ **NO KNOWN ALLERGIES**

Allergy Type	Please describe allergic reaction severity & symptoms
☐ **Medication**	
☐ **Contrast**	
☐ **Latex**	

MEDICATIONS

☐ **Not currently taking any medication.**

Medication Name	Dose And Instructions

SURGICAL HISTORY:

_____

_____

_____

_____

HEALTH AND PREVENATIVE SCREENINGS:

Men's Health			
Colonoscopy	Date:	Provider	Abnormal/Normal? Y/N
Prostate Exam	Date:	Provider	Abnormal/Normal? Y/N
Bone Density	Date:	Provider	Abnormal/Normal? Y/N
Eye Exam	Date:	Provider	Abnormal/Normal? Y/N
Women's Health			
Eye Exam	Date:	Provider	Abnormal/Normal? Y/N
Pap Smear	Date:	Provider	Abnormal/Normal? Y/N
Mammogram	Date:	Provider	Abnormal/Normal? Y/N
Colonoscopy	Date:	Provider	Abnormal/Normal? Y/N
Bone Density	Date:	Provider	Abnormal/Normal? Y/N
Date of First Menses		Age of First Menstrual Cycle:	
Total Number of Pregnancies:		Pregnancy Complications Y N	
Total Number of Live Births:		Age of Menopause:	

MEDICAL HISTORY (CHECK ALL THAT APPLY)

Condition	You	Father	Mother	Paternal Grandfather	Paternal Grandmother	Sibling(s)	Aunt or Uncle
Anxiety							
Asthma							
Arthritis							
Cancer							
Stoke							
Diabetes Type 1							
Diabetes Type 2							
Heart Attack							
Heart Disease							
Heart Failure							
High Blood Pressure							
High Cholesterol							
Thyroid Problems							
Migraines							
Depression							
Urinary or Kidney Problems							
Prostate Problems							
COPD/Emphysema							

SOCIAL HISTORY

Cigarette Smoking	Alcohol/Caffeine Use	Drug Use	Exercise
☐ Never Smoked ☐ Former smoker ☐ E Cigs _____ ☐ Smokes daily # packs per day: _____	☐ Do not drink alcohol ☐ Less than 1 drink a day ☐ 1-2 drinks a day ☐ 3 or more drinks a day **Caffeine** Do not drink caffeine ☐ No ☐ Yes How Many per day?	☐ Illicit Drugs Type: _____ ☐ IV Drug use	☐ Yes ☐ No If yes, how many days per week? _____ What type of exercise? _____

VACCINE HISTORY:

Do you take Vaccines? Y /N	**Last Pneumonia Vaccine:**
Last Tetanus Booster or Tdap:	**Last Prevnar Vaccine:**
Last Flu Vaccine:	**Last Shingles Vaccine:**

DEPRESSION SCREENING:

In the past 2 weeks, how often have you been bothered by any of the following problems?

1. **Have you had little interest or pleasure in doing things?**
   ☐ Not at all ☐ Some Days ☐ More than half the days ☐ Nearly every day

2. **Feeling down, depressed or hopeless?**
   ☐ Not at all ☐ Some Days ☐ More than half the days ☐ Nearly every day

COGNITIVE FUNCTIONAL STATUS:

1. **Do you have problems with your hearing?** ☐ Yes ☐ No
2. **Do you have problems with your vision?** ☐ Yes ☐ No
3. **Have you fallen in the past 12 months?** ☐ Yes ☐ No If Yes, How many times? _____

Patient OR Guardian Signature: _____ **Date:**_____