BRAVOURE

PRIMARY CARE
FOR WOMEN

# Complete Intake Form for Non-Medicare Pts

**Checklist of items to bring to your first visit:**

1. Registration forms
2. Photo ID
3. List of your current medications and dosages
4. Previous medical records from doctors, hospitals, if applicable

**Important Information about our practice:**

Regular office hours: Monday through Thursday from 9:00AM to 4:00PM unless prior arrangements are made. Please call during these hours for all routine matters such as appointments, prescription refills, referrals and general questions.

**Telephone calls during office hours:**

When calling the office, always call the same number: 845-241-0040. There may be times when you may need to leave a message for a call back.

**Prescription refills:**

The best way to get prescriptions refilled is to send a text message or use the REFILL REQUEST button on the website: www.bravourewellness.com.

**Test results:**

When diagnostic testing or labs are ordered, you will be scheduled to discuss the results, or we will coordinate a time to discuss those results. We will alert you if an emergent problem is detected.

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**Appointments:**

Appointments can be made by phone or you can use the online booking option through our secure website: www.bravourewellness.com. Appointments made online will remain tentative until confirmed by our staff.

Appointment cancelations are a part of life but we would appreciate at least 24 hours notice.

**Forms:**

Prior authorization forms and other forms will be completed by our office over 5-7 business days. Please allow sufficient time if you require forms to be completed. Please provide all of the necessary forms required to be completed so that all of the information can be addressed during your visit.

**Communication Via E-mail and Patient Portal messaging, Text messaging:**

Limit email content to non-urgent medical questions and matters. Please do not use email or the patient portal to communicate urgent situations. If an urgent situation occurs, please contact the office by phone. If you are experiencing a medical emergency, dial 911 or go to the nearest Emergency Department. Although we will attempt to reply to your messages and emails as quickly as possible, it may take more than one business day. In some cases we may call you by phone directly rather than respond by text or email. Emails intended for discussion of symptoms, clinical questions or therapy adjustment with communication between you and your doctor over a period of several days are considered an E-Visit. These may be subject to additional fees if you are not enrolled in our membership plan.

**Controlled Substance Prescriptions:**

Controlled substances such as narcotics will be prescribed only if your doctor considers them as indicated and necessary.

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**Code of Conduct:**

For the health and safety of all patients and staff of Integrated Rheumatology Care we expect to treat each other with dignity and respect and adhere to the following: • Respect other patients' right to privacy, which is protected by federal law. • Violent, aggressive, and/or inappropriate behaviors are not permitted and will not be tolerated. Any verbal and/or physical threats or actions against staff and/or other patients will be grounds for discharge from our practice. • Sexual misconduct, including sexual assault, harassment, exploitation, or intimidation of staff and/or patients, or unwelcome behaviors of a sexual nature is grounds for discharge from our practice. • Personal belongings and valuables are the responsibility of the individual patient. Our practice will not be responsible for any lost or missing items. • Weapons, recreational drugs, alcohol and smoking are not permitted in our office. • During Telehealth visits (also called telemedicine), patients should be in a private location where they can speak freely about their health, patients should be fully dressed for their video visits and cannot be driving or walking on the street during these visits.

Name (print): _____

Signature _____

Date _____

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**Patient Demographics Form:**

Full name: _____

Date of birth: _____

Primary phone: _____ Home mobile (please circle one)

Secondary phone: _____ Home mobile work (please circle one)

Email: _____

Address: _____

_____

Emergency Contact:_____

Relationship to patient: _____

Phone number: _____

Email address:_____

Address: _____

Preferred Pharmacy:

Name: _____

Address: _____

Phone number: _____

Please take the time to fill out this form. This information will help the provider get ready for your visit.

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Name of your primary care provider: _____

How did you learn of Bravoure Medical Wellness?_____

What is the reason for your visit? _____

_____

**Review of Systems:** Please circle if you are experiencing any of the following:

Fatigue
Weakness of a limb
Fever
Abdominal pain
Night sweats
Constipation
Weight loss
Diarrhea
Weight gain
Heartburn
Nausea/Vomiting
Dry eyes
Blurred vision/double vision
Redness in the eyes
Vision loss
Jaundice
Foamy urine

Change in the color of your urine
Blood in urine
Painful urination
Difficulty with urination
Waking up at night to pass urine
Hearing loss
Ringing in ears
Loss of smell
Nosebleeds
Nose sores
Mouth sores
Skin ulcers
Skin rashes
Itchy skin
Difficulty swallowing
Hoarseness of voice
Cough

Shortness of breath
Coughing up blood
Wheezing
Snoring/sleep apnea
Chest pain
Irregular heartbeat/palpitations
Shortness of breath at night
Muscle pain
Morning stiffness
Joint pain/Joint swelling
Neck pain
Back pain
Headaches
Difficulty with balance/vertigo
Depression
Anxiety
Numbness/Tingling of a limb

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**Health Maintenance Questionnaire: Please complete if applicable for age/gender:**

Have you have had a chest x-ray over the last year? Yes No (please circle one)

Date of last mammogram (women age 40 and older): _____

Date of your last bone density test (DEXA) (post-menopausal women and men older than 70 years): _____

Date last colonoscopy (patients 45 and older): _____

Date of last eye exam: _____

**Procedures/Surgical History: Please circle if you have had any of the following surgeries/ procedures:**

Angioplasty/Cardiac Stents

Cardiac bypass surgery

Cardiac pacemaker placement

Carpal Tunnel Surgery

Hernia Repair

Hip replacement

Knee replacement

Back surgery

Neck surgery

Appendectomy

Spleen removal

Gallbladder removal (cholecystectomy)

Blood transfusion

Tonsillectomy

Thyroid surgery

Fracture repair

Cataract extraction

Hysterectomy with or without ovary removal

C-section Chemotherapy

Radiation

Bariatric surgery
(gastric bypass or sleeve, lap band)

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**Gynecologic history (women only):**

Date of last menstrual period: _____

Currently using birth control: yes no

If using birth control, what are you using? _____

Last pap smear: _____

History of abnormal pap smear: yes no (please circle)

Number of pregnancies:_____

Number of miscarriages/pregnancy losses: _____

**Social History: Please check if you have a history of any of the following:**

Current tobacco use (cigarette, cigar, pipe, chewing tobacco, smokeless tobacco, vape)

Former tobacco use

Never used tobacco

Alcohol daily use > 2 drinks per day

Caffeine > 2 cups per day

Marijuana use – medicinal or recreational

Recreational drug use (cocaine, etc.)

Opioid abuse/dependence

**Marital Status: Circle one**

Never married Married Divorced Separated Widowed

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**Occupation (type of work):** _____

**Immunization history:**

Flu vaccine  Pneumonia vaccine  Zoster/shingles vaccine  Covid-19 vaccine

**Medication allergies:** Please list below

_____

_____

**What is your most recent height and weight?**

Weight: _____

Height: _____