

Anchor Internal Medicine

New Patient Form

Agnes Kinra, MD PA

Dana Coker Kingdon, PA-C

4104 West 15th St #101 Plano, TX 75093

Phone 972-596-0006 Fax 972-596-0904

Name:

DOB:

☐ Male ☐ Female Email Address:

Check Preferred: ☐ Cell ☐ Home

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Pharmacy and intersection or phone number:

Allergies and Adverse Reactions to Medications

Name of Medication or Substance	Reaction/ Side Effect

Medications and All Supplements

[illegible]

Reason for your visit today:

Current or Past Medical Problems

Condition	Current	Past	Approximate Onset	Comments
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Elevated Lipids	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Other lung Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		
Autoimmune Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Osteopenia or Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		
Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>		
Other GI Issues	<input type="checkbox"/>	<input type="checkbox"/>		
Iron Deficiency	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>		
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>		
Alcohol overuse	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Type of Surgery	Date/Year	Type of Surgery	Date/Year

Mental Health

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
Little Interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead or hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Habits

1. Which of the follow describes you?						
<input type="checkbox"/> Never Smoked or Used other Tobacco Product (Skip to question 2)						
<input type="checkbox"/> Current Smoker: How many cigs per day?				For how many years?		
<input type="checkbox"/> Occasional Smoker		<input type="checkbox"/> Do you use other form of Tobacco ? Describe:				
<input type="checkbox"/> Former Smoker or other Tobacco User: For how long ?				Quit Date?		
2. Do you drink Alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many per day?		How many per week?	
Do you worry that you drink too much?						

Vaccinations

<input type="checkbox"/> Tetanus (dT)	Date	<input type="checkbox"/> Prevnar 13	Date	<input type="checkbox"/> Gardasil (HPV)	Date
<input type="checkbox"/> Tetanus with Whooping cough (Tdap)	Date	<input type="checkbox"/> Pneumovax 23	Date	<input type="checkbox"/> Flu Shot	Date
<input type="checkbox"/> Hepatitis B	Dates	<input type="checkbox"/> Shingrix	Dates	<input type="checkbox"/>	Date
<input type="checkbox"/> Hepatitis A	Dates	<input type="checkbox"/> COVID	Dates	<input type="checkbox"/>	Date

Health Maintenance

Colon Cancer Screening <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cologuard Test <input type="checkbox"/> Other	Date	Findings/When due Again	Doctor
Dilated Eye Exam	Date	If Diabetic was there any Diabetic Retinopathy found? <input type="checkbox"/> Yes <input type="checkbox"/> No	Doctor
Mammogram	Date	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Facility
Bone Density	Date	Findings <input type="checkbox"/> Normal <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis	Doctor/ Facility
Pap/ Pelvic	Date	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Doctor
PSA/Prostate Exam	Date	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Doctor

Family History

[illegible]

Other Physicians, Please list

Name/ Specialty	Name/ Specialty

Fall Screening (Medicare Patients Only)

Have you had any falls in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you suffer any injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments
Do you feel you are at risk of falling? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Activities of Daily Living: Do you have trouble:

Keeping your balance when walking?	<input type="checkbox"/> No Issues	<input type="checkbox"/> Need mild assistance	<input type="checkbox"/> Always need help
Getting out of chairs and walking without assistance?	<input type="checkbox"/> No Issues	<input type="checkbox"/> Need mild assistance	<input type="checkbox"/> Always need help
Climbing Stairs?	<input type="checkbox"/> No Issues	<input type="checkbox"/> Need mild assistance	<input type="checkbox"/> Always need help
Carrying out shopping, cooking, driving, managing finances?	<input type="checkbox"/> No Issues	<input type="checkbox"/> Need mild assistance	<input type="checkbox"/> Always need help
Do you have a living will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Need Information