Health History

New Patient

Name: _____

DOB: _____

Please describe the reason for your visit today.

_____

Medications *(List any medications or vitamins you are taking)*

Medication name	Dose and frequency	Need Refill Today(Y/N)?

Allergies (foods and drugs)
Please list any known allergies

_____

Have you been diagnosed with any of the following?

Anemia	Yes	No	GERD	Yes	No	Myocardial infarction	Yes	No
Anxiety	Yes	No	GI Bleed	Yes	No	Prostate Cancer	Yes	No
Asthma	Yes	No	Gout	Yes	No	Renal Failure	Yes	No
Atrial Fibrillation	Yes	No	Hepatitis A	Yes	No	Renal insufficiency	Yes	No
Chicken Pox	Yes	No	Hepatitis B	Yes	No	Seizures	Yes	No
Chronic Back Pain	Yes	No	Hepatitis C	Yes	No	Skin cancer	Yes	No
Colon cancer	Yes	No	Hypertension	Yes	No	Stroke	Yes	No
Deep Vein Thrombosis	Yes	No	Hyperthyroidism	Yes	No	Substance Abuse	Yes	No
Depression	Yes	No	Hypothyroidism	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Kidney stones	Yes	No			

Surgical History

Please list any surgeries and the year you had them

_____

_____

_____

Family History

Please list any known diseases in your family

_____

_____

_____

Social History

Alcohol Use Yes / No Type: _____ Drinks / Week : _____

Drug Use: Yes / No Type: _____ Use / Week: _____

Tobacco Use: Yes / No Type: _____ Packs / Day: _____

Quit Date: _____ Years: _____

Preventative Care:

Colonoscopy (patients over 50)

Have you had a Colonoscopy? Yes / No

Year: _____

Normal : Yes / No

Immunizations

When was your last tetanus vaccine _____

When was your last flu vaccine _____

When was your last pneumonia vaccine _____

Osteoporosis (bone thinning and weakening)

When was your last bone mineral density _____

Where_____

Do you know the results _____

Males only

Testicular Cancer

When was your last testicular exam_____

Prostate Cancer Screening

When was your last exam_____

PSA?_____

Females only

Cervical Cancer

When was your last pap smear _____

☐ Normal ☐ Abnormal

Have you had a hysterectomy ☐ Yes ☐ No

Have you ever been diagnosed with cervical, uterine or ovarian cancer? ☐ Yes ☐ No

What type _____

Mammogram

When was your last mammogram _____

☐ Normal ☐ Abnormal