Name: _____
DOB: _____
Date: _____
MR#: _____

Health History

New Patient

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Were you referred by another physician? If so, who?

_____

Please describe the reason for your visit today. Please include the date of onset and any symptoms associated with the problem.

_____
_____
_____
_____

Medications *(Include vitamins and over the counter medications)*

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

Pharmacy you use most often (Name and Location)

_____
_____

Allergies (foods and drugs)
Please indicate type of reaction next to each.

_____
_____

Advanced Directives
Do you have Advanced Directives? (such as living will, power of attorney, etc.) Yes No
If yes, please specify.

_____
_____

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Medical History

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

Surgical History

Abdominal Aneurysm	Yes	No	Cholecystectomy	Yes	No	Lung Transplant	Yes	No
Appendectomy	Yes	No	Colon Surgery	Yes	No	Neck Surgery	Yes	No
Back Surgery	Yes	No	Femoral Popliteal Bypass	Yes	No	Percutaneous Transluminal Coronary Angioplasty	Yes	No
Bariatric Surgery	Yes	No	Heart Transplant	Yes	No	Pneumonectomy	Yes	No
Brain Surgery	Yes	No	Hip Surgery	Yes	No	Prostate surgery	Yes	No
CABG	Yes	No	Kidney removal	Yes	No	Shoulder Surgery	Yes	No
Cardiac catheterization	Yes	No	Kidney transplant	Yes	No	Sinus surgery	Yes	No
Carotid endarterectomy	Yes	No	Knee Arthroscopy	Yes	No	Tonsillectomy	Yes	No
Carpal Tunnel Release	Yes	No	Knee Surgery	Yes	No	Valve Replacement	Yes	No
Cataract removal/IOL implant	Yes	No	Liver Transplant	Yes	No	Vasectomy	Yes	No
Cerebral Aneurysm	Yes	No						

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Family History *(mark all that apply)*

Relationship	No Known Problems	Alcohol abuse	Alzheimer's disease	Asthma	Autoimmune disease	BRCA 1/2	Breast cancer	Cancer	Colon cancer	COPD	Depression	Diabetes	Heart disease	Hyperlipidemia	Hypertension	Inflammatory bowel ...	Learning disability...	Lung cancer	Melanoma	Osteoporosis	Ovarian cancer	Parkinsonism	Prostate cancer	Seizures	Thyroid cancer	Thyroid disease	Other
Mother																											
Father																											
Sister																											
Brother																											
Daughter																											
Son																											
Maternal Aunt																											
Maternal Uncle																											
Paternal Aunt																											
Paternal Uncle																											
Maternal Grandmother																											
Maternal Grandfather																											
Paternal Grandmother																											
Paternal Grandfather																											

Social History

Marital Status (circle one): Single Married Divorced How many children do you have? _____

Who do you live with? _____

What is your occupation? _____

How many years of education do you have?_____

Do you have home health? If so, please list name of company._____

Name: _____
DOB: _____
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Alcohol Use: Yes No Alcohol/Week: _____

Drinks/Week: _____ Glasses of wine Comments: _____

_____ Cans of beer

_____ Shots of liquor

_____ Standard drinks or equivalent

Sexually Active: Yes No Not Currently

Birth Control / Protection: *(circle all that apply)*

Abstinence Coitus interruptus Condom Diaphragm Implant Injection Inserts IUD OCP Patch Post-menopausal Rhythm Spermicide Sponge Surgical Other-see comments None

Partners: Female Male

Comments: _____

Drug Use: Yes No

Types: *(circle all that apply)* Amphetamines Amyl nitrate Anabolic steroids Barbituates Benzodiazepines "Crack" cocaine Cocaine Codeine Fentanyl Flunitrazepam GHB Hashish Heroin Hydrocodone Hydromorphone Ketamine LSD Marijuana MDMA (Ecstacy) Mescaline Methamphetamines Methaqualone Methylphenidate Morphine Nitrous oxide Opium Oxycodone PCP Psilocybin Solvent inhalants Other-see comments

Use/week: _____

Comments: _____

Tobacco Use: Yes No If Yes, How often? _____

Quit Date: _____

Types: Cigarettes Pipe Cigars Electronic Cigarette

Packs/day: _____

Years: _____

Smokeless Tobacco: Yes No Types: Snuff Chew

Quit Date: _____

Name: _____
DOB: _____
Date: _____
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Preventative Care:

We strongly believe that prevention is the key to keeping you happy and healthy. We closely follow national recommendations in screening for cancer, heart disease, cholesterol problems, diabetes, high blood pressure, osteoporosis, and many vaccine preventable diseases.

In order to help us with our goal please also fill out the following.

When was your last physical exam or well woman exam? _____

Cholesterol

Have you had your cholesterol levels tested in the last 5 years?

☐ Yes ☐ No

_____

☐ Normal ☐ High

If high, what was the number _____

Colon Cancer Screening (for patients over 50)

Have you ever had colon cancer screening? ☐ Yes ☐No

Colonoscopy? If so when _____

Where_____

Sigmoidoscopy? If so when _____

Where_____

Barium Enema? If so when_____

Where_____

Hemoccult/Blood in stool? If so when_____

Where_____

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 _____

Where _____

☐ 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 breast exam_____

When was your last mammogram _____

Where _____

☐ Normal ☐ Abnormal

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Review of Systems *(circle all that apply)* Please indicate whether you have recently (last month) had problems with any of the following.

General: Decreased appetite, Dizziness, Fatigue, Fever, Weakness, Unintentional weight loss, Weight gain

Eyes: Eye discharge, Halos, Eye irritation, Recent visual changes

Ears, Nose and Throat: Allergy/sinus problems, Difficulty swallowing, Disruptive snoring, Earache, Hearing loss, Nasal Congestion, Postnasal drip, Runny nose, Sneezing, Voice change

Cardiovascular: Chest pain, Leg cramps with exertion, Palpitations/irregular heartbeats, Swelling of the hands or feet, Passing out

Respiratory: Chest congestion, Cough, Coughing up blood, Shortness of breath, Sleep disturbance due to breathing, Wheezing

Gastrointestinal: Abdominal bloating, Abdominal pain, Change in bowel habits, Difficulty swallowing, Constipation, Diarrhea, Acid reflux/indigestion, Black tarry stool, Nausea, Rectal bleeding, Vomiting

Genitourinary - Female: Decreased libido, Breast pain, Pain with urination, Pain with intercourse, Blood in the urine, Urinary incontinence, Nipple discharge, Pelvic pain, Urinary frequency, Urinary urgency, Vaginal discharge, Vaginal dryness

Genitourinary - Male: Decreased libido, Decreased urinary flow, Discharge Pain with urination, Erectile dysfunction, Blood in the urine, Urinary incontinence, Urinating at night, Urinary frequency, Urinary hesitancy

Musculoskeletal: Back pain, Joint pain, Joint swelling, Muscle aches, Muscle cramps

Dermatologic: Acne Hair loss, Nail problems, Itching, Rash, Changing moles

Neurological: Difficulty walking, Double vision, Frequent falling, Headaches, Muscle weakness, Numbness Seizures, Sudden loss of vision, Tremors

Psychiatric: Anxiety, Depression, Insomnia

Endocrine: Excessive thirst, Excessive urination, Intolerance to cold, Intolerance to heat

Hematological: Easy bruising, Abnormal bleeding, Enlarged lymph nodes

Allergy: Itchy eyes, Hives, Seasonal allergies