Health History
New Patient

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

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

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

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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Past Medical History/Problems (check all that apply)

__ Abnormal Pap Smear
__Anemia
__ Anxiety
__Asthma
__ Atrial Fibrillation
__ Bipolar Disorder
__ Blood Transfusion
__ Breast Ca.
__ Cervical Ca.
__ Chronic Back Pain
__ Colon Cancer
__ COPD
__ Crohns Disease
__ CVA /Stroke
__ Dementia
__ Depression
__ Diabetes, Gestational
__ Diabetes Type 1
__ Diabetes Type 2
__ Diverticulosis
__ DVT
__ Dyslipidemia
__ Fibrocystic Breast Disease
__ GERD
__ Gout
__ GI Bleed (upper/lower)
__ Coronary Heart Disease
__ Congestive Heart Failure
__Valvular Heart Disease
__ Hepatitis A
__ Hepatitis B
__ Hepatitis C
__ Hypertension
__ Hyperthyroidism
__ Hypothyroidism
__ Kidney Stone
__ Liver Disease
__ Heart Attack
__ Osteoarthritis
__ Osteoporosis
__ Peptic Ulcer Disease
__ Peripheral Vascular Disease
__ Prostate Cancer
__ Renal Failure
__ Renal Insufficiency
__ Rheumatoid Arthritis
__ Seizure Disorder
__ Skin Cancer
__ Substance Abuse
__ Thyroid Disorder
__ Tuberculosis
__ UTI – recurrent
__ Varicose Veins/Phlebitis
__NO MEDICAL PROBLEMS

Please explain any items you checked and list any medical problems not included:

_____
_____
_____
_____

Past Surgical History (check all that apply)

__ No surgeries
__ Abdominal Surgery-type
__ Aneurysm Repair
__ Appendectomy
__ Left Aortic-Femoral Bypass
__ Right Aortic-Femoral Bypass
__ Bilateral A-F Bypass
__ Aortic Valve
__ Breast Augmentation
__ Breast Lumpectomy
__ Breast Reduction
__ Bronchoscopy
__ Cardiac/ Heart Cath
__ Carpal Tunnel
__ CABG
__ Carotid Endarterectomy
__ Cataract Extraction
__ C-Section
__ Cervical Discectomy
__ Cholecystectomy
__ Colon Resection
__ Craniotomy
__ Gastric Lap Band
__ Cryn Surgery
__ Hernia Repair – Inguinal
__ Hernia Repair- Umbilical
__ Hip Replacement
__ Hysterectomy w/BSO
__ Knee Arthroscopy/scope
__ Knee Replacement
__ Lumbar Discectomy
__ Mastectomy
__ Mitral Valve Replacement
__ Nephrectomy
__ Stent Placement
__ Lung Resection
__ Prostatectomy
__ Rotator Cuff Re
__ Tonsillectomy
__ Tubal Ligation
__ Transplant Heart
__ Transplant Liver
__ Transplant Lung
__ Transplant Kidney
__ Sinus Surgery
__ Uterus/Ovary Surgery
__ Vasectomy
__ Surgery Complications
__ Yes __ No
__Anesthesia Complications
__ Yes __ No __
__ Other

Please list any surgeries not included:

_____
_____
_____
_____

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Family History:

Has any blood relative (father, mother, siblings, grandparents, aunts or uncle or other) had any of the following? If so, please list who next to problem.

___ Alcoholism _____
___ Allergies _____
___ Anxiety _____
___ Asthma _____
___ Autoimmune _____
___ Blood Clots _____
___ Breast Cancer _____
___ Cervical Cancer _____
___ Colon Cancer _____
___ Colon Polyp _____
___ Migraine _____
___ Prostate Cancer _____
___ Stroke _____
___ Depression _____
___ Diabetes _____
___ Cholesterol _____
___ Heart Disease _____
___ High Blood Pressure _____
___ Liver Disease _____
___ Lung Cancer _____
___ Melanoma _____
___ Osteoperosis _____
___ Seizures _____
___ Other _____
___ NEGATIVE FAMILY HISTORY

Social history

Marital Status (circle one): Single Married Divorced How many children do you have? _____
Who do you live with? _____
What is your occupaion? _____
How many years of education do you have? _____
Do you have home health? If so, please list name of company. _____

Risk Factors

Tobacco Use: Yes___ No___ Current: Yes___ No___ Year started_____ Packs/Day_____ Cigars/week_____
Year Quit: _____ Smokless cans/day_____
Alcohol Use: Yes___ No___ Drinks/day_____ Type_____
Drug Use: Yes___ No___ Type/Frequency_____
Caffeine Use (circle one) Rare Sometimes Heavy
Exercise (Circle one) Never Some days Most days Daily
Seatbelt Use (circle one) Never Sometimes Always
Sun Exposure (circle one) Remote Rarely Occasionally Frequently
Heart Attack in Father before age 55 Yes___ No___
Heart Attack in Mother before age 65 Yes___ No___

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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