Today's Date ___________________ MRN _________________________

New Patient Health History

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete each question.

Name ____ **Birthdate**_________________________

Who referred you to our practice? ____

Drug Allergies (please list specific reaction to each, especially if life-threatening)

____

Medications (List all including vitamins and supplement with doses and frequency of each – may attach lit if desired.)

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

Pharmacy name and address

____

Specialist Seen

____

Medical Problems (list every medical problem that you have including high cholesterol, diabetes, high blood pressure, abnormal pap smear, cancer, lung/heart/stomach/kidney/liver disease, & psychiatric disorders- **include year of onset for each**)

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

Past Surgeries (Ex: tonsils, appendix, gallbladder, cataracts, stents, breast biopsy, tubes tied, plastic surgery, prostate)

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

Family History: Living? Age/Age at Death? Health Problems/Cause of Death (Ex: Heart Attack, Cancer, Stroke, Diabetes, Hypertension)

Mother____

Father ____

Brother ____

Sister ____

M Grandmother ____

M Grandfather ____

P Grandmother ____

P Grandfather ____

Please list any illnesses that are prominent in other family members ____

Today's Date ___________________ MRN _______________________

Social History: **Tobacco Use** (circle one) Current / Quit / Never Start Date _____________ Quit Date ___________

Type ________________________ Quantity _________ per day / week Smokeless Y / N _______ cans/day

Alcohol Use (circle one) Y / N Type of Alcohol __________________ Average number of drinks per week _______________

Have you ever or do you currently use illegal drugs? Y / N Type ____

Sexually Active Yes / No / Not Currently Birth Control/Protection Type ____

Marital Status (circle one) Single / Married / Partnered / Divorced / Separated / Widowed

# of Children: ___________ Occupation: ________________________________

Health Maintenance:

Exercise - Do you exercise at all? Y / N If yes how many times per week? ________ Type ________________________

Last colonoscopy ___________________________ Normal / Abnormal Next due______________

Last Tetanus vaccine ___________________________ TDaP (with whooping cough) or plain TD

Last Pneumonia vaccine _______________________ Pneumovax 23 / Prevnar 13 Last Shingles _____________________

Last Flu vaccine ____________________________ Last Dexa/Bone Density ____________________________

Women Only:

Last Pap smear _________________ Normal / Abnormal Last mammogram _________________ Normal / Abnormal

Men Only:

Last PSA ____________________ Normal / Abnormal

Do you have an Advanced Directive? ____