Name_____ DOB _____ Date_____

New Patient Health History - To become part of medical record

Previous doctor:_____ Referred to the practice by:_____

Reason for Visit: (Please list your major medical concerns):

Medications: List your prescribed and over the counter drugs, such as vitamins					
Drug Name	Strength	Frequency	Drug Name	Strength	Frequency

PAST MEDICAL HISTORY Please check any of the following that you have been diagnosed with.

□ Anorexia/Bulimia
□ Anemia
□ Anxiety/Depression
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blocked Heart Arteries (IHD)
□ Blood Clots
□ Bronchitis
□ Cancer Type:_____
□ Cataracts
□ Chronic Constipation
□ Colon Polyps
□ COPD
□ Macular Degeneration
□ Degenerative Disc Disease
□ Diabetes/Pre-Diabetes
□ Diverticulitis
□ Emphysema
□ Frequent Urinary Infections
□ Gallstones
□ GERD - Reflux
□ Glaucoma
□ Gout
□ Headaches
□ Heart Attack (MI)
□ Heart Failure (CHF)
□ Heart Murmur
□ Hemorrhoids
□ Hepatitis
□ Herniated Disc
□ High Blood Pressure (HTN)
□ High Cholesterol/Triglycerides
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory Bowel Disease (IBD)
□Ulcerative colitis
□Crohn's
□ Insomnia
□ History of Blood Transfusion
□ Irritable Bowel Syndrome (IBS)
□ Kidney Disease (Renal Insufficiency)
□ Kidney Stones (Nephrolithiasis)
□ Meningitis
□ Obesity
□ Osteopenia
□ Osteoporosis
□ Peripheral Vascular Disease/Poor Circulation
□ Pneumonia
□ Prostate Enlargement (BPH)
□ Rheumatic Fever
□ Seasonal Allergies
□ Seizures
□ Sleep Apnea
□ Stroke (CVD)
□ Tuberculosis (TB)
□ Varicose Veins
□ Ulcers / Gastrointestinal (Peptic Ulcer)
□ Alcohol Abuse Quit Date: _____
□ Substance Abuse Quit Date: _____

□ Any Others_____

Allergies			
Drug Name	**Reaction You Had**	**Drug Name**	**Reaction You Had**
1.		**3.**	
2.		**4.**	

Women's Health

Last Menstrual Peroid: _____
Abnormal PAP's? _____
Age at first period: _____

Number of Pregnancies: _____
Number of Miscarriages: _____
Number of Abortions: _____
Number of C-Sections: _____

Name_____ DOB _____ Date_____

Surgical / Procedure History – Please check any of the following you have had, and list the month/year performed.

	Year		Year		Year
□ Appendectomy	_____	□ C-Section	_____	□ Joint Surgery	_____
□ Bunionectomy	_____	□ Cataract Removal	_____	□ Cardiac Bypass	_____
□ Carotid Surgery	_____	□ Hemorrhoidectomy	_____	□ Gallbladder Removal	_____
□ D&C	_____	□ Hip Replaced/Repair	_____	□ Hernia Repair	_____
□ Lumpectomy	_____	□ Kidney Stones	_____	□ Cardiac Stents	_____
□ Lasik Surgery	_____	□ Hip Replacement	_____	□ Thyroidectomy	_____
□ Tonsillectomy	_____	□ Prostate Removed	_____	□ Knee Replacement	_____
□ Tubal Ligation	_____	□ Ovaries Removed (Oophorectomy)	_____	□ Vasectomy	_____
□ Uterus Removal (Hysterectomy)	_____			□ Back Surgery	_____

□ Any Others _____

Other Hospitalizations – Please list any other hospitalizations that you have had		
Reason	Date	Hospital

Family History			
Relation	**Age**	**Age at death**	**Significant Health Problems**
Father		**N/A**	
Mother		**N/A**	
Sister		**N/A**	
Brother		**N/A**	
(Other)		**N/A**	

Physicians you have recently seen			
Name of physician	**Specialty**	**Reason**	**Last visit-Mo/Yr**

HEALTH MAINTENANCE If you have had any of the following performed, please check the box and list the month/year

□ Last Physical Exam _____
□ Last EKG _____
□ Last Eye Exam _____
□ Labs including a Cholesterol Screen _____

□ Colonoscopy _____
□ Fecal Occult Blood Test (Blood in stool) _____

□ Shingles Vaccine (Zostavax) _____
□ Human Papilloma Virus Vaccine (HPV-Gardasil) _____
□ Vaccines Against Hepatitis _____
□ Influenza Vaccine _____

□ Mammogram (Females Only) _____
□ Clinical Breast Exam (Females Only) _____
□ Pap Smear (Females Only) _____
□ Bone Density _____

□ PSA (Males Only) _____

□ Tetanus Diphtheria (Td) _____
□ Tetanus Diphtheria Pertusis (Tdap) _____
□ Pneumonia Vaccine (Pneumovax) _____
□ TB Screening _____

Name_____ DOB _____ Date_____

SOCIAL HISTORY

Are you a: □ Current Smoker □ Former Smoker □ Non smoker

If a current smoker, how often do you use cigarettes? □ Every day □ Some days but not every day

If a current smoker, how many cigarettes a day do you smoke? _____

If a former smoker amount smoked per day(e.g. packs)?_____ How long did you use tobacco?:_____ Quit Date? _____

Are you sexually active? □ Yes □ No □ Never Do you use condoms? □ Yes □ No
Sexual Partners: □Male □Female □ Both
Do you have any history of STD's? □ No □ Yes If yes, what type? _____

Do you use illicit drugs? □ No □ Yes Type: _____
Do you have a history of drug addiction? □ No □ Yes Type: _____

How often did you have a drink containing alcohol in the past year?
□ Never □ Monthly or less □ 2 to 4 times/month □ 2 to 3 times/week □ 4 times or more/week

How many drinks did you have on a typical day when you were drinking in the past year?
□ 1-2 drinks □ 3-4 drinks □ 5-6 drinks □ 7-9 drinks □ 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?
□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

How many drinks containing caffeine do you take in typical day?_____

Number of Children - Sons _____ Daughters_____ Ages of Children: _____

Have you ever been, a victim of domestic violence? □ No □ Yes

Regular Exercise □ Yes □ No Type:_____ Frequency:_____

Currently Living with? □ Alone □ Sibling □ Spouse □ Children □ Parents □ Significant Other □ Friend/Roommate

What is your current marital status? □ Single □ Married □ Divorced □ Widowed □ Other: _____

Your Occupation: _____ If retired, prior occupation: _____

Do you have pets? □ Yes □ No If yes please describe: _____

Hobbies/interests and physical activities: _____

The CDC recommends that everyone be screened for the risk of HIV. Do you have any concerns about possible exposure that you would like to discuss or be tested for? □ Yes □ No

Do you have special dietary preferences/restrictions? □ No □ Yes If yes, what type? _____

Please indicate any spiritual/religious preferences/restriction: _____

If you use any other medical suppliers (oxygen, CPAP, home health, etc.) please list those company names below:

_____

Name_____ DOB _____ Date_____

Please check any of the following symptoms that you are currently experiencing or have experienced in the last 7-10 days.

GENERAL
□ Recent Fever
□ Excessive Fatigue
□ Unexplained Weight Loss/Gain

EYES
□ Discharge
□ Pain or Burning
□ Blurred Vision
□ Loss of Sight
□ Itching or Watering

BREAST
□ Pain
□ Lumps
□ Nipple Discharge

RESPIRATORY
□ Cough
□ Coughing up Blood
□ Shortness of Breath
□ Wheezing
□ Snoring

REPRODUCTIVE-WOMEN
□ Irregular Periods
□ Spotting between periods
□ Vaginal discharge/burning/itching
□ Unusually painful periods
□ Pain/Trouble during intercourse

REPRODUCTIVE-MEN
□ Discharge from Penis
□ Pain or Swelling of Testicles
□ Pain/Trouble during intercourse
□ Problems with Erection

MENTAL HEALTH
□ Thoughts of Suicide
□ Marital Problems
□ Trouble Sleeping
□ Panic Attacks
□ Anxiety
□ Thoughts of Harming Others

SKIN
□ Change in Nails
□ Lumps
□ Recurrent Rashes
□ Sores that will not heal or bleed
□ Moles that are changing

EARS
□ Hearing Loss
□ Ringing
□ Earache
□ Feeling of Ear Fullness

MOUTH & THROAT
□ Dry Mouth
□ Soreness or Bleeding in mouth area
□ Sore Throat
□ Mouth Ulcers
□ Hoarseness
□ Dental Issues

ENDOCRINE
□ Unusual intolerance of heat
□ Unusual intolerance of cold
□ Excessive Thirst
□ Excessive Hunger

URINARY
□ Pain/Burning with Urination
□ Frequent Urination
□ Blood in Urine
□ Trouble starting to Urinate
□ Waking up to Urinate
□ Leakage of Urine
□ Change in Stream

NERVOUS SYSTEM
□ Headaches
□ Seizures/Convulsions
□ Fainting Spells
□ Frequent Memory Loss
□ Weakness
□ Shakiness or Tremor
□ Loss of Sensation/Numbness
□ Feeling of Tingling in Limb
□ Speech Difficulty

NOSE & SINUSES
□ Bleeding
□ Nasal Congestion
□ Sneezing
□ Loss of Sense of Smell

NECK
□ Pain
□ Lumps

CARDIOVASCULAR
□ Abnormal/Irregular Heart Beat
□ Chest Pain
□ Awaken at night with breathing problems
□ Passing Out
□ Shortness of Breath
□ Swelling of Ankles
□ Leg Pain/Resting
□ Leg Pain/Walking

GASTROINTESTINAL
□ Unable to eat certain foods
□ Loss of Appetite/Weight
□ Food sticks in throat
□ Painful Swallowing
□ Heartburn
□ Indigestion
□ Vomiting
□ Nausea
□ Vomiting Blood
□ Abdominal or Stomach Pain
□ Diarrhea
□ Constipation
□ Recent Change in Bowel Habits
□ Blood in Stools
□ Black Stools

MUSCULOSKELETAL
□ Joint Pain
□ Joint Stiffness
□ Muscle Soreness

BLOOD DISORDERS
□ Easy Bruising
□ Excessive Bleeding

Patient Signature:_____