NEW PATIENT HISTORY FORM

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

Yes No Yes No

\_\_\_ \_\_\_ Recent Illness \_\_\_ \_\_\_ Sexual Concerns

\_\_\_ \_\_\_ Weight Gain \_\_\_ \_\_\_ Back Pain

\_\_\_ \_\_\_ Weight Loss \_\_\_ \_\_\_ Joint Pain

\_\_\_ \_\_\_ Fever \_\_\_ \_\_\_ Rash

\_\_\_ \_\_\_ Vision Change \_\_\_ \_\_\_ Itching

\_\_\_ \_\_\_ Hearing Loss \_\_\_ \_\_\_ Seizure

\_\_\_ \_\_\_ Sinus Congestion \_\_\_ \_\_\_ Headaches

\_\_\_ \_\_\_ Chest Pain \_\_\_ \_\_\_ Depression

\_\_\_ \_\_\_ Palpitations \_\_\_ \_\_\_ Anxiety

\_\_\_ \_\_\_ Murmur \_\_\_ \_\_\_ Irregular Periods

\_\_\_ \_\_\_ Varicose Veins \_\_\_ \_\_\_ Anemia

\_\_\_ \_\_\_ Shortness of Breath \_\_\_ \_\_\_ Rhinitis

\_\_\_ \_\_\_ Cough \_\_\_ \_\_\_ Urinary Incontinence

\_\_\_ \_\_\_ Diarrhea \_\_\_ \_\_\_ Urinary Urgency

\_\_\_ \_\_\_ Constipation \_\_\_ \_\_\_ Urinary Frequency

\_\_\_ \_\_\_ Blood in Stool \_\_\_ \_\_\_ Urinary Burning

\_\_\_ \_\_\_ Heartburn

Have you had these immunization, and if so when: Tetanus Shot\_\_\_\_\_\_

Shingles vaccine\_\_\_\_\_\_ Pnuemovax\_\_\_\_\_\_ Prevnar 13\_\_\_\_\_\_\_

Last Colonoscopy\_\_\_\_\_\_

Do you have a Living Will?\_\_\_\_\_\_ Do you have a durable POA for Healthcare?\_\_\_\_\_\_

Do you smoke?\_\_\_\_\_ How much?\_\_\_\_\_\_ Have you ever smoked?\_\_\_\_\_\_ How much/How long?\_\_\_\_\_\_

Drink Alcohol?\_\_\_\_\_\_ How often?\_\_\_\_\_\_ How much?\_\_\_\_\_\_

Do you use Marijuana or other substance?\_\_\_\_\_\_

Are you married/single/divorced/other?\_\_\_\_\_\_\_

Do you feel safe in your current living situation?\_\_\_\_\_\_

Any history of abuse (verbal/physical/sexual)?\_\_\_\_\_\_ (can leave blank and discuss privately with doctor if desired)

Do you wear your seatbelt?\_\_\_\_\_\_

Do you exercise?\_\_\_\_\_\_ If so, how often?\_\_\_\_\_\_

Please list all specialists you are seeing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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IF FEMALE:

Last period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Age at Menopause\_\_\_\_\_\_\_\_\_\_

Number of Pregnancies\_\_\_\_\_ C-Sections\_\_\_\_ Vaginal Birth\_\_\_\_ Miscarriage\_\_\_\_

Elective Abortion\_\_\_\_

Last Mammogram done\_\_\_\_\_\_\_ Last Pap done\_\_\_\_\_\_

PAST MEDICAL HISTORY

Do you have history of any medical problems, such as: \_\_\_\_\_hypertension, \_\_\_\_\_diabetes, \_\_\_\_\_asthma, \_\_\_\_\_heart disease, \_\_\_\_\_thyroid disorder, \_\_\_\_\_cancer, \_\_\_\_\_other (please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history of medical problems (cancer, heart disease, diabetes, hypertension, etc.)

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandparents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY OTHER CONCERNS YOU MAY WANT TO ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PREFERRED PHARMACY/CITY OR ZIP CODE/PHONE NUMBER

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