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_____

_____

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:_____

_____

PREFERRED PHARMACY/CITY OR ZIP CODE/PHONE NUMBER

_____