New Patient Form

(age 16 and over)

Name: ______________________________ Date of Birth: ____/____/____ Age: _____

PAST MEDICAL HISTORY

Please check **to the right** of each item if you have ever had any of the following problems:

High Cholesterol		Tuberculosis		Gout	
High Triglycerides		Positive TB skin test		HIV/AIDS	
High Blood Pressure		Asthma		Seasonal Allergies	
Coronary Heart Disease		Ulcers		Glaucoma	
Heart Attack		Gallstones		Epilepsy/Seizures	
Valve Problem/Murmur		Hepatitis		Migraine Headaches	
Congestive Heart Failure		Colon Polyps		Depression	
Blood Transfusion		Diverticulitis		Anxiety	
Diabetes		Crohn's Disease		Psychiatric Problems	
Thyroid Problems		Ulcerative Colitis		Alcohol/Substance Abuse	
Osteoporosis		Kidney Disease		STDs	
Cancer (type): _________		Kidney Stones		Abnormal Pap Smear	
Anemia		Prostate Problems		Other:_____________________	
Emphysema		Frequent UTIs		____________________________	
Chronic Bronchitis		Arthritis		____________________________	

HEALTH MAINTENANCE HISTORY

For dates, please give the month and year to the best of your ability.

FOR WOMEN ONLY:

Last Menstrual Period: ___/___ or __ post-menopausal   Last Pap Smear: ___/___

Have you ever had an abnormal pap smear? (please circle one) yes no If yes, date: ___/___

Last Mammogram: ___/___ or __ NONE   Last Bone Density: ___/___ or __ NONE

FOR BOTH MEN AND WOMEN:

Last Tetanus Shot: ___/___ or __ not sure, but more than 10 years ago

Pneumonia Vaccine: ___/___ or __ NONE

Have you ever had a screening test for colon cancer? __ yes __ no
If yes, please indicate below which test(s) you've had:
__Hemoccult stool card ___/___   __Flexible Sigmoidoscopy ___/___   __Colonoscopy___/___

Have you ever had your cholesterol checked? __ yes __ no
If yes, date: ___/___ Were results normal? __ yes __ no __ unsure

PAST OBSTETRIC AND GYNECOLOGIC HISTORY (Women Only)

Please answer the following or indicate yes or no.

Age of First Period		# of Pregnancies		Are you post-menopausal?	
# of Days in Each Cycle		# of Deliveries		If yes, age of menopause	
# of Days with flow		# of Miscarriages		Any bleeding since menopause?	
Date of last period	___/___	# of Abortions		Are you on hormones?	
		# of Living Children			

SURGICAL HISTORY

Have you ever had any surgery or been hospitalized/had a serious illness? (please circle one) YES NO

If yes, please list below:

Past Surgeries	Date	Past Hospitalizations/Serious Illnesses	Date

MEDICATIONS

Please list your current medications (both prescription and over-the-counter), including dose and frequency.

DRUG NAME	DOSE	HOW OFTEN

ALLERGIES

Are you allergic to any medications? (please circle one) YES NO

If yes, please list the medication(s) and the reaction(s) below:

MEDICATION	REACTION

FAMILY HISTORY

Please check **to the left** those that apply and list the relationship to the right. Include parents, grandparents, siblings, and aunts/uncles, and if possible please specify maternal (mother's side) or paternal (father's side); you can abbreviate M or P for short.

	High Blood Pressure			Breast Cancer	
	Heart Attack			Colon Cancer	
	Other Heart Trouble			Ovarian Cancer	
	Stroke			Prostate Cancer	
	Diabetes			Uterine Cancer	
	Thyroid Disease			Alcoholism	
	Asthma			Depression	
	Hepatitis			Other Mental Illness	
	Tuberculosis			Other Cancer:______________	
	Migraine Headaches			Other: ____________________	
	Epilespy/Seizures				

Have any of your parents or siblings died before the age of 55? If yes, please describe: ____________________

____

SOCIAL HISTORY

Please take a few minutes to answer these questions so that we may better know you.
Please circle when applicable.

Marital Status: single married living w/ partner (male - female) separated divorced widowed

Current Occupation(s): ____

Education Completed: Jr. High High School/GED Some College College
Graduate School Professional Degree

Do you have any children? yes no If yes, please list names and ages: ______________________________

____

HEALTH HABITS HISTORY

Do you exercise? yes no If yes, what type? _____________________ How Often? _________________

Do you limit your fat intake? yes no

Do you eat much in the way of fruits and vegetables? yes no Approximately how many servings a day? ___

How many servings of milk or dairy foods do you eat a day? _____

Do you take any calcium supplements? yes no If yes, what kind and how much? _____________________

Do you **currently** smoke cigarettes, cigars, or chew tobacco? yes no
If yes, how much per day? ___________ For how many years total? ___________

Did you smoke or chew in the past? yes no If yes, how many per day? ____ For how many years total?____

Do you drink beer, wine, or liquor? yes no
If yes how many times per week? ____________ How many drinks do you have at a time? ________________

Have you ever had a problem with alcohol in the past? yes no
If yes, please describe: ____

Have you **ever** used street drugs? yes no If yes, please circle ALL that apply:
IV drugs amphetamines cocaine heroin marijuana downers inhalants other:____________

Are you currently using any street drugs? yes no If yes, please circle ALL that apply:
IV drugs amphetamines cocaine heroin marijuana downers inhalants other:____________

Have you been sexually active during the past year? yes no If yes, please circle ALL that apply:
1 partner multiple partners male partner(s) female partner(s)
If yes, what birth control are you using? ____

Safety profile: Do you wear a seatbelt? yes no Do you have a smoke alarm in your home? yes no
If you ride a bike, do you wear a helmet? yes no not applicable

Date of last eye exam: ____/____ Date of last dental cleaning/exam: ____/____

REVIEW OF SYSTEMS

Please put a check **to the right** of any symptoms or problems that you are currently experiencing.

Weight gain		Chest pain		Blood in urine		Fainting/blackout	
Weight loss		Shortness of breath		Sexual difficulty		Loss of speech	
Fatigue		Coughing blood		Irregular periods		Easy bruising	
Fever		Wheezing		Painful menses		Excessive sweating	
Night sweats		Frequent indigestion		Sores on penis/vagina		Heat intolerance	
Mole changes		Frequent regurgitation		Vaginal discharge		Cold intolerance	
Headache		Chronic diarrhea		Breast discharge		Feelings of depression	
Vision changes		Chronic constipation		Breast lumps		Nervousness/anxiety	
Difficulty hearing		Bloody/black stools		Breast pain/tenderness		Sleeping problems	
Persistent cough		Frequent urination		Joint pains		Other: _____________	
Nasal congestion		Bladder leakage		Back pain			
Heart palpitations		Hard to empty bladder		Lightheaded/dizzy			