New Patient Health History Today's Date ______ / _____ / _______

Name ____ Birth Date ______ / ______ / ________

What is the reason for your visit today? ____

____

Do you have a primary care provider?

Name of Provider ____

Address ____

Street Address City State Zip Code

PAST MEDICAL HISTORY: Please circle **Yes** or **No** for any illnesses that you have had:

Hepatitis	Yes	No	Anemia	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Immune Disorders	Yes	No	Asthma/Bronchitis/Emphysema	Yes	No
Intestinal Problems	Yes	No	Bleeding/Bruising	Yes	No
Kidney Disease	Yes	No	Blood Disorder	Yes	No
Liver Disease	Yes	No	Cancer (type):	Yes	No
Lung Disease	Yes	No	Depression/Emotional Problems	Yes	No
Skin Disease	Yes	No	Diabetes	Yes	No
Stroke	Yes	No	Drug/Alcohol Dependency	Yes	No
Stomach Ulcers	Yes	No	Epilepsy/Seizures	Yes	No
Thyroid Disease	Yes	No	Hay Fever/Sinus Problems	Yes	No
Other (describe):	Yes	No	Heart Problems	Yes	No

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please list the date(s) and reason(s):

____

____

____

Have you had any surgeries? ☐ Yes ☐ No If yes, please list the date(s) and type(s) of surgery:

____

Please list any medications you take, including prescription drugs, over-the-counter drugs, eye drops, vitamins, minerals, and herbs:

Name of Medication ***Dose or Strength*** ***How often do you take it?***

Have you ever had an allergic reaction to a medication? ☐ Yes ☐ No If yes, which medication(s)?

Medication **Reaction**

Have you had an allergic reaction to any of the following?

Latex ☐ Yes ☐ No Iodine ☐ Yes ☐ No Other allergies: ______

Insect stings ☐ Yes ☐ No Food ☐ Yes ☐ No (If yes, describe) ______

FAMILY HISTORY: Have any members of your family, (including grandparents, parents, siblings, and children), had any of the following? Please circle Yes or No:

Problem	Yes	No	Family Relationship
Alcoholism/Substance Abuse	Yes	No	
ALS (Lou Gehrig's Disease)	Yes	No	
Alzheimer's/Dementia	Yes	No	
Anemia/Bleeding Problems	Yes	No	
Cancer (Breast, Ovarian, Colon, Other)	Yes	No	
Depression/Other Mental Illness	Yes	No	
Diabetes	Yes	No	
Heart Disease/Angina	Yes	No	

Hepatitis/Liver Disease	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Kidney Disease	Yes	No	
Osteoporosis	Yes	No	
Seizure Disorders	Yes	No	
Stroke	Yes	No	
Thyroid Disease	Yes	No	
Tuberculosis	Yes	No	
Other (please describe):	Yes	No	

SOCIAL HISTORY: Please tell us about your lifestyle and personal habits. It is OK if you choose not to answer any of these questions.

What is your occupation? ____ Are you retired? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No If no, who do you live with? _______________________________________

Do you follow any special diet? ☐ Yes ☐ No If yes, describe _______________________________________

Do you drink milk or eat cheese, yogurt, or dark leafy greens daily? ☐ Yes ☐ No

Do you have concerns about your nutrition? ☐ Yes ☐ No If yes, describe _____________________________

____

Do you exercise regularly? ☐ Yes ☐ No If yes, describe ____

What are the main sources of stress in your life? Describe ____

____

Do you use chewing tobacco or snuff? ☐ Yes ☐ No Do you smoke cigars or cigarettes? ☐ Yes ☐ No

If the answer is **Yes**, answer the questions below:	If the answer is **No**, answer the questions below:
For how many years have you smoked?	Have you smoked in the past? ☐ Yes ☐ No
How many packs per day do you smoke?	How many packs per day did you smoke?
Are you interested in quitting?	When did you quit?

Do you drink alcohol? ☐ Yes ☐ No   If yes, please answer the questions in the box:

During the last week, on how many days have you had a drink?	
On days when you had a drink, how many drinks (beer, wine, or liquor) did you have?	
Have you ever felt that you ought to cut down on drinking?	☐ Yes ☐ No
Have people criticized your drinking?	☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking?	☐ Yes ☐ No
Have you ever had to have a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes ☐ No
Have you ever had blackouts or memory loss?	☐ Yes ☐ No

Do you use or take any drugs such as marijuana, cocaine, stimulants, or sedatives? ☐ Yes ☐ No

If yes, describe _______________________________ Have you ever injected drugs? ☐ Yes ☐ No

Have you had sex with men? ☐ Yes ☐ No   Have you had sex with women? ☐ Yes ☐ No

Do you and your sexual partner(s) practice safe sex? ☐ Yes ☐ No ☐ Not sure

Risk factors for infection with HIV, the AIDS virus, include anal intercourse or vaginal intercourse with multiple partners, intravenous drug use, hemophilia, past history of a blood transfusion between 1979 – 1985, and sexual contact with an HIV-positive individual or other person with these risk factors. If you have any of these risk factors, or are interested in being tested for HIV infection, please discuss this with your health care provider.

In the last 12 months, have you been hurt or felt threatened by someone close to you? ☐ Yes ☐ No

During the past month, have you felt "down" or depressed? ☐ Yes ☐ No

Do you have trouble finding pleasure in the things you used to enjoy? ☐ Yes ☐ No

Have you ever been so sad that you thought about hurting yourself? ☐ Yes ☐ No

PREVENTIVE CARE:

Have you received a vaccine to prevent any of the following diseases? If yes, please list date.

Tetanus (DT)	Yes	No	Date:	Influenza (flu)	Yes	No	Date:
Pneumonia	Yes	No	Date:	Hepatitis B	Yes	No	Date:
Rubela/MMR	Yes	No	Date:	HPV	Yes	No	Date:

Have you ever had any of these screening tests done? If yes, please give date of last test.

Cholesterol	Yes	No	Date:
Tuberculin skin test	Yes	No	Date:
Stool test for blood	Yes	No	Date:
Sigmoidoscopy or colonoscopy	Yes	No	Date:
Mammogram	Yes	No	Date:
Bone density test	Yes	No	Date:

Do you have any problems paying for medical care? ☐ Yes ☐ No

PAIN AND FUNCTIONAL STATUS: As health care providers, we are concerned about your comfort.
Do you suffer from pain? ☐ Yes ☐ No If yes, please answer the questions in the box below:

Where is your pain? ____

What does your pain feel like? ____

Circle a number from 0-10 that best describes how much pain you are having now:

|----------|----------|----------|----------|----------|----------|----------|----------|----------|
1 2 3 4 5 6 7 8 9 10
No Pain Worse Pain Possible

What makes the pain better? ____

What makes the pain worse? ____

Does the pain limit your activity or interfere with your sleep? If yes, please describe: ____________

____

Please list any medication(s) or other type(s) of treatment you use for pain relief: ______________

____

An Advance Health Care Directive is a document that provides instructions regarding your medical care in the event of serious medical problems. It also allows you to define who may make health care decisions for you if you are unable to make decisions for yourself. It has previously been called a "Living Will" or "Durable Power of Attorney for Health Care."

Do you have an Advance Health Care Directive? ☐ Yes ☐ No

If no, would you like information about Advance Directives? ☐ Yes ☐ No

REVIEW OF SYSTEMS:

Have you experienced any of the following **in the past 3-6 months?**

- Change in general health ☐ Yes ☐ No Comments:
  Recent weight changes
  Recurrent fevers, chills, or sweats
  Heat or cold intolerance
  Extreme fatigue
  Change in appetite
  Excess thirst or urination
  Difficulty sleeping

- Nervousness/anxiety ☐ Yes ☐ No Comments:
  Difficulty sleeping
  Depression
  Delusions/hallucinations

- Easy bruising ☐ Yes ☐ No Comments:
  Frequent or prolonged bleeding
  Enlarged lymph nodes
  Decreased resistance to infection

- Unusual rash/skin problems ☐ Yes ☐ No Comments:
  Delayed healing
  Change in hair or nails

- Headaches ☐ Yes ☐ No Comments:
  Numbness/tingling sensation
  Weakness/paralysis
  Convulsions/seizures
  Confusion/change in memory or concentration
  Black outs/dizziness

- Change in hearing/ringing in ears ☐ Yes ☐ No Comments:
  Recent nose bleeds
  Chronic sinus problems/runny nose
  Allergy symptoms
  Voice changes
  Recurrent sore throat
  Difficulty swallowing

- Wear glasses or contact lenses ☐ Yes ☐ No Comments:
  Change in vision
  Pain or irritation in eye(s)
  Redness or discharge in eye(s)

- Breathing problems/shortness of breath ☐ Yes ☐ No Comments:
  Chronic cough
  Coughing-up blood

- Chest pain or angina ☐ Yes ☐ No Comments:
  Irregular heart rhythm/palpitations
  Swelling of feet, ankles, hands
- Breast pain ☐ Yes ☐ No Comments:
  Breast lump or swelling
- Severe heartburn ☐ Yes ☐ No Comments:
  Nausea or vomiting
  Vomiting blood
  Abdominal pain
  Constipation
  Frequent diarrhea
  Black or bloody stools
- Joint/muscle stiffness, pain, weakness ☐ Yes ☐ No Comments:
  Neck pain/back pain
  Difficulty walking

Please answer the following questions:

Have you ever had a mammogram? ☐ Yes ☐ No If yes, please give date and results of last mammogram and where mammogram was done.
Date: ____ / ____ / ______ Location: ___________________________ Results: ______________________

Have you ever had an abnormal mammogram? If yes, please give date, results, and treatment.
Date: ____ / ____ / ______ Results: __________________________ Treatment: ________________________

Do you routinely practice self-breast exams? ☐ Yes ☐ No

Have you ever had sexually transmitted disease, genital or anal warts? ☐ Yes ☐ No

When was your last PAP smear? Date: ____ / ____ / ______ Results: ________________________________

Have you ever had an abnormal PAP smear? ☐ Yes ☐ No If yes, please give date, results and treatment.
Date: ____ / ____ / ______ Results: _______________________ Treatment: __________________________

Do you have problems with any of the following? Comments:

Urinary infrequency/urgency ☐ Yes ☐ No
Frequent urination at night ☐ Yes ☐ No
Lack of bladder control/incontinence ☐ Yes ☐ No
Painful urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Recurrent urinary tract infections ☐ Yes ☐ No
Vaginal discharge ☐ Yes ☐ No
Vaginal pain/itching/irritation ☐ Yes ☐ No
Vaginal dryness ☐ Yes ☐ No
Hot flashes ☐ Yes ☐ No
Change in sex drive ☐ Yes ☐ No

Bleeding between periods/after menopause ☐ Yes ☐ No
Pain during intercourse ☐ Yes ☐ No

How old were you when you had your first menstrual period? Age: __________

Do you still have menstrual periods? ☐ Yes ☐ No

If you are still having periods, on what day did your last period start? Date: ____ / ____ / ______

Are your periods regular? ☐ Yes ☐ No How many days are there between periods? Days: ___________

How long does your period last? Days: ___________ Are your periods painful? ☐ Yes ☐ No

How would you describe your period? (Circle answer) Heavy Moderate Light

Have you ever been on hormone replacement therapy? If yes, give dates/type

Dates: ____________________________ Type: ____

Have you ever been pregnant? If yes, please fill in total number of pregnancies, deliveries, miscarriages, and abortions.
# of pregnancies: _______ # of deliveries: ________ # of miscarriages: ________ # of abortions: _________

Did you have complications with a pregnancy? If yes, please describe: _______________________________

____

Do you currently use any form of birth control? If yes, please state type used: _________________________

Have you used Plab B in the past 12 months? ☐ Yes ☐ No If yes, how many times? ____________

Are you concerned that you may be pregnant? ☐ Yes ☐ No

Have you had sexual intercourse without using birth control since your last period? ☐ Yes ☐ No

Provider Signature ______________________________________ Date _____ / _____ / _________