**New Patient Health History**

**Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Best phone number to contact you**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous providers seen (please include Primary Care and Specialists):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What was your gender at birth? Male Female Decline to answer**

**What gender do you currently identify as? Male Female Decline to answer**

**Do you have an Advanced Directive or a Living Will? Yes No If yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***If you have this at home, please bring it with you.***

**Do you need an interpreter? Yes No Preferred language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**American Sign Language Interpreter: Yes No Tactile Sign Interpreter: Yes No Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hearing impaired? Yes No Do you wear glasses or have corrective lenses? Yes No**

**Current medications, vitamins, supplements OR attach list of medications, vitamins and supplements**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy of Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:** (Please list medications and specify type of reaction)

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

**YOUR MEDICAL HISTORY**

🞏 Anemia

🞏 Anxiety

🞏 Arthritis

🞏 Asthma

🞏 Blood Transfusion

🞏 Cancer Type**:**\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Cataracts

🞏 Congestive Heart Failure (CHF)

🞏 Clotting Disorders

🞏 COPD (Chronic Obstructive Pulmonary Disease)

🞏 Depression

🞏 Diabetes

🞏 Emphysema

🞏 Environmental Allergies

🞏 GERD

🞏 Glaucoma

🞏 Heart Murmur

🞏 HIV/AIDS

🞏 Hyperlipdemia

🞏 Hypertension

🞏 Kidney Disease

🞏 Meningitis

🞏 Heart Attack (Myocardial infarction)

🞏 Nerve/Muscle Disease

🞏 Osteoporosis

🞏 Seizures

🞏 Sickle Cell Anemia

🞏 Stroke

🞏 Substance Abuse

🞏 Thyroid Disease

🞏 Tuberculosis

🞏 Ulcers

🞏 OTHER \_\_\_\_\_\_\_\_

**YOUR SURGICAL HISTORY**

🞏 Appendectomy

🞏 Brain Surgery

🞏 Breast Surgery

🞏 Coronary Artery Bypass Surgery

🞏 Gallbladder removal

🞏 Colon Surgery

🞏 Cosmetic Surgery

🞏 C-section #\_\_\_\_\_\_

🞏 Eye Surgery

🞏 Fracture Surgery

🞏 Hernia Surgery

🞏 Hysterectomy

🞏 Ovaries Removed

🞏 Joint Replacement

🞏 Prostate Surgery

🞏 Small Intestine Surgery

🞏 Spine Surgery

🞏 Tubal Ligation

🞏 Valve Replacement

🞏 Vasectomy

🞏 OTHER \_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**Marital Status**: Married, Single, Divorced, Separated, Widowed, Partnership

Who lives in your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education** (Level completed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Safety**

Do you wear seatbelts? Yes No

Are you sexually active? Yes No

Do you feel safe in your current relationship?

Yes No

Have you ever been hit, lapped, physically hurt or threatened by your partner? Yes No

Is anyone misusing your money or property? Yes No

Do you wear sunscreen? Yes No

Do you have firearms in your home? Yes No

**Exercise**

How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco**

**Do you use any of the following?**

Cigarettes, Pipe, Cigar, E-Cigarette, Vaping

Smokeless Tobacco: Snuff, Chew

Former Current Never

Year quit: \_\_\_\_\_\_ Number of years you used tobacco: \_\_\_\_\_ Number of packs/day: \_\_\_\_\_\_

**Alcohol**

**Do you drink any of the following?**

Beer, Wine, Liquor, Other

On average how many drinks per week? \_\_\_\_\_

**Drugs**

**Do you use any of the following?**

Marijuana, Amphetamines, Cocaine, Heroin, Narcotics, Anti-Anxiety Medication, Barbiturates, Inhalants

**FAMILY HISTORY**

| **Relationship & Name** | **Current Age** | **Age at Death** | **Arthritis** | **Asthma** | **Birth defects** | **Cancer (Type)** | **COPD** | **Depression** | **Diabetes** | **Premature Death** | **Hearing loss** | **Heart Disease** | **High Blood Pressure** | **High Cholesterol** | **Kidney Disease** | **Learning Disabilities** | **Mental Illness** | **Miscarriages** | **Stroke** | **Substance Abuse** | **Vision Loss** | **OTHER** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mother** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Father** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Sister** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Sister** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Brother** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Brother** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Child** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Child** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Maternal Grandmother** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Maternal Grandfather** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Paternal Grandmother** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Paternal Grandfather** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Aunt** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Aunt** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Uncle** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Uncle** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **OTHER \_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**HEALTH MAINTENANCE - FEMALE**

Age of First Menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of Menopause (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_

Last menstrual period: \_\_\_\_\_\_\_\_ Number of days \_\_\_\_\_\_\_

Length of time between periods: \_\_\_\_\_\_\_\_\_\_\_\_\_

Menstrual Flow *(Circle all that apply)*:

Heavy, Moderate, Light, Painful, Irregular, Prolonged

Do you have either of the following? Itching Discharge

Do you perform self-breast exams? Yes No

Date of last Pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an abnormal Pap? Yes No

Current contraception type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a sexually transmitted disease? Yes No

Number of Pregnancies: \_\_\_\_\_\_\_\_\_\_

Number of Live Births: \_\_\_\_\_\_\_\_\_\_\_ Miscarriages: \_\_\_\_\_\_\_\_\_

Stillbirths: \_\_\_\_\_\_\_\_\_ Abortions: \_\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_

Date of last colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_

Date of last bone density scan: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH MAINTENANCE - MALE**

Date of last PSA: \_\_\_\_\_\_\_\_\_\_\_ Date of last colonoscopy: \_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Prostate/Rectal exam: \_\_\_\_\_\_\_\_\_ Do you perform self-testicular exams? Yes No

**IMMUNIZATIONS**

Date of last:

Influenza Vaccine: \_\_\_\_\_\_\_\_\_\_\_ Pneumonia Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_ Tetanus or TDAP Vaccine: \_\_\_\_\_\_\_\_\_\_\_ Shingles: \_\_\_\_\_\_\_\_\_\_\_\_\_\_