

New Patient History

Patient Name: _____ **Date of Birth:** _____

Referring Physician Name: _____

I have a: Living will Durable Medical Power of Attorney for Healthcare

Emergency Contact Name: _____

Relationship to Patient: _____ Phone: _____

Previous Surgeries/Hospitalizations:

Date	Location	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Chronic Medical Conditions:

Arthritis: Y N Renal/Kidney Disease: Y N Cancer: Y N Type: _____
 Gastrointestinal: Y N High Blood Pressure: Y N Others: _____
 Cardiac/Heart: Y N Diabetes: Y N

Have you ever received blood transfusions or blood products? Yes No When: _____

Family History

Mother: Diabetes Cancer: Breast/Colon/Ovary Heart Disease High Cholesterol Deceased
Father: Diabetes Cancer: Colon/Prostate Heart Disease High Cholesterol Deceased
Siblings: Diabetes Cancer: _____ Heart Disease High Cholesterol Deceased
Other: _____

Allergies: None Food Drugs Latex Other: _____

Medications

All prescription medications & doses and over the counter medications/herbs/supplements routinely taken:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Spiritual Screen

Do you have any spiritual, cultural or ethic beliefs/practices that we should be aware of? Yes No

If yes, please describe: _____

Lifestyle and Health Management Screen

Tobacco: Yes No Amount: _____ Date started: _____ Date quit: _____

Alcohol: Yes No Amount: _____ Date started: _____ Date quit: _____

Recreational Drugs: Yes No Amount: _____ Date started: _____ Date quit: _____

Marital Status: Married Divorced Single Widow/Widower

Occupation: _____ Retired? Yes No

Do you exercise? Yes No Type: _____ How Often: _____

Have you received a Tetanus vaccine within the last 10 years? Yes No If yes, date received: _____

Have you received a Pneumonia vaccine? (age 65 or older) Yes No If yes, date received: _____

Have you received a Flu vaccine this year between October-March? Yes No If yes, date received: _____

Have you received a shingles vaccine? Yes No If yes, date received: _____

Date of last colonoscopy: _____

Women Only:

Date of last period: _____ Last pap smear: _____ Last breast exam: _____ Last mammogram: _____

Cycles (please check one): Regular Irregular

How many pregnancies: _____ How many children: _____

Do you have a gynecologist? Yes No Doctor's name: _____

Abuse Screen

Are you in a relationship where you are being hurt, kicked, slapped, or made to feel afraid? Yes No

Any additional information pertinent to your medical history not previously listed: _____

