HIGHLANDS FAMILY MEDICINE - NEW PATIENT HISTORY FORM

Name ______________________________________ **Today's Date** __________________
Birthdate __________________________________

How did you hear about us?
Internet   Insurance   Health Care Provider (Who? ______________________________)
Friend or Relative (Who? ____________________________)   Other ___________________________

MEDICATIONS: Please list medications you currently take (including over the counter medications)
Please list any additional medications on back of form

Medication Name	Dose/Frequency

ALLERGIES: Please list any allergies you have, and your reaction

Food or Drug Allergy	Reaction

IMMUNIZATIONS: Please indicate if and when you had these immunizations

Immunization	Date Received
Flu shot Y N	
Pneumonia shot Y N	
Shingles shot Y N	
Tetanus shot Y N	
Did the tetanus shot include whooping cough (pertussis)? Y N	

MEDICAL PROBLEMS: Please list any significant illnesses that you have/had

Problem	Year

SURGERIES:

Surgery	Date

SCREENING: **When was your last?**

Screening	Year	Screening	Year
Physical Exam		Pap Smear	
Colonoscopy		Mammogram	
Prostate Exam		Bone Density Test	

FAMILY HISTORY:

Relation	Age (or age at death)	Medical Problems or Cause of Death
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Brother/Sister		
Brother/Sister		
Brother/Sister		

Brother/Sister		
Other (uncles/aunts,etc)		

HAS ANY FAMILY MEMBER HAD?

Cancer of the breast Y N	Heart Disease Y N
Cancer of the colon Y N	High Blood Pressure Y N
Cancer of the prostate Y N	Depression Y N
Other type of cancer Y N	Other mental illness Y N
Diabetes Y N	Alcoholism Y N

SOCIAL MEDICAL HISTORY:

Marital Status: Single Married Divorced Separated Widowed
Partnered Civil Union In a Relationship Other

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Occupation: ____________________

Hobbies: ____________________

DO YOU:

Drink alcohol? Y N *Formerly?* Y N *Year Quit?* ________	**Type of alcohol?** **Amount per day/week/month?** ________
Use tobacco? Y N *Formerly?* Y N *Year Quit?* ________	**Smoke** Y N **Amount per day?** ______ **Chew** Y N **Amount per day?** ______
Use recreational drugs? Y N *Formerly?* Y N	**What type?**
Exercise regularly? Y N	**What type?** **Times per week?**
Are you concerned about your risk of HIV/AIDS? Y N	