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	
COVID 19 shot ☐Y ☐N	
COVID 19 Booster ☐Y ☐N	

CONTINUED ON OTHER SIDE →

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

(EXAMPLE: DIABETES, HIGH BLOOD PRESSURE, ASTHMA…)

Problem	Year

SURGERIES:

Surgery	Date

SCREENING: **When was your last?**

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

FAMILY HISTORY:

Relation	Alive?	Age of death?	Medical Problems or Cause of Death
Father	Y N		
Mother	Y N		
Paternal Grandfather	Y N		
Paternal Grandmother	Y N		
Maternal Grandfather	Y N		
Maternal Grandmother	Y N		
Brother/Sister	Y N		
Brother/Sister	Y N		
Brother/Sister	Y N		
Brother/Sister	Y N		
Other (uncles/aunts, etc.)	Y N		

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 *Drink alcohol in past?* ☐ Y ☐ N *Year Quit?* _____	**Type of alcohol?** **Amount per day/week/month?** _____
Use tobacco? ☐ Y ☐ N *Use tobacco in past?* ☐ Y ☐ N *Year Quit?* _____	**Smoke** ☐ Y ☐ N **Amount per day?** _____ **Chewing tobacco** ☐ Y ☐ N **Amount per day?** _____
Use recreational drugs? (Including marijuana) ☐ Y ☐ N Use of drugs in past? ☐ Y ☐ N Year quit? _____	**What type?**
Exercise regularly? ☐ Y ☐ N	**What type?** **Times per week?**
Are you concerned about your risk of HIV/AIDS? ☐ Y ☐ N *Any history of std's in past?* ☐ Y ☐ N	