

Adult History New Patient Form

PLEASE BRING ALL MEDICATION(S) TO YOUR APPOINTMENT.

Please complete this form and bring it with you to your visit.

Date: _____

Name: _____ Date of Birth: _____
 (Last) (First) (Middle)

Birth Sex: Male Female **Current Gender Identity:** Choose not to disclose Female Female-to-Male/Transgender Male
 Undifferentiated Genderqueer Male Male-to-Female/Transgender Female

Preferred Pronoun: Decline to answer He, Him, His She, Her, Hers They, Them, Theirs Ze, Hir Other _____

Single Married Widow(er) Partner Divorced **Who do you live with?** Alone Partner Family Other

Email: _____ Would you like to enroll in the Patient Portal? Yes No

Occupation: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Insurance: _____ Policy Number: _____

Having race, ethnicity and language information for all of our patients helps us know them better.

Race: Alaskan Native or American Indian Asian Black or African American Native Hawaiian or Other Pacific Islander
 White Unknown Other _____ Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Primary Language: English Spanish Other _____ Declined

Are there any other languages spoken in the home? If yes, please list:

Preferred Pharmacy: _____

Address: _____

Phone: _____ Fax: _____

Routine Check Up – No Symptoms

Reason for Visit: *(please list all current symptoms)*

1. _____
 2. _____
 3. _____

Chronic Problems:

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

Do you take your medications as directed? Yes No
**Please bring all medications to your visit in a bag.*

Name of Medication	Dosage	Times Per Day
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

Supplements / Herbs / Over the counter medication:

1. _____
 2. _____

Allergies:

Source	Reaction	Source	Reaction
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Have you ever had any of the following?

(If yes, enter date to those that apply)

TEST	Date
Eye Exam	_____
Dental Exam	_____
Cholesterol	_____
PPD (TB test)	_____
HIV test	_____
Hepatitis C	_____
Stool blood test	_____
Colonoscopy	_____
Bone density	_____
Chest X-Ray	_____
Heart Stress Test	_____
Blood transfusion	_____
MRI	_____
Sleep Study	_____
Other	_____

Surgical History	Date	Surgical History	Date
Angioplasty	_____	Heart Valve	_____
Appendectomy	_____	Hernia repair	_____
Arthroscopy of knee	_____	Hip/Knee replacement	_____
Back surgery	_____	Hysterectomy	_____
CABG (Heart bypass)	_____	Why did you have a hysterectomy?	_____
Carpal tunnel release	_____		
Cataract extraction	_____	Was your cervix removed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Colon resection	_____	Were your ovaries removed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Colostomy	_____	Did you have a vaginal hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Defibrillator	_____	LASIK	_____
Fracture	_____	Mastectomy	_____
Location: _____		Small bowel resection	_____
Gallbladder out	_____	Thyroidectomy	_____
Gastric bypass	_____	Tonsillectomy	_____
Gastric Band	_____	Pacemaker	_____
Gastric Sleeve	_____	Prostate surgery	_____
		Other	_____

Other recent physician or hospital visits:

1. _____ 2. _____ 3. _____

Social History (Check all that apply)

Alcohol Use Yes No Former

Years Drinking _____

Drinks per week _____

Type _____

Quit date _____

Last drink _____

Caffeine Yes No Amount/week

Coffee _____

Pop/Soda _____

Energy drinks _____

Other: _____

Exercise Yes No

Frequency (Hours/week): _____

Types:

Tobacco Yes No Former

Cigarettes

Packs per day _____

Cigars

Chewing Tobacco

Would like to quit

Years of use _____

Year quit _____

Sexual History

Are you currently sexually active?

Yes No

Any history of sexually transmitted diseases? Yes No

If yes, when?

Recreational drug use

Yes No Former

Have you ever used IV drugs?

Yes No

Personal safety

Do you wear your seatbelt?

Yes No

Do you have difficulty dressing yourself?

Yes No

Do you have difficulty carrying 10 pounds?

Yes No

Do you have difficulty shopping?

Yes No

Other

Have you experienced a fall in the last year? Yes No If yes, how many times have you fallen this year? _____

Were you injured in the fall(s)? Yes No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things Not at all Several days More than half the days Nearly daily

Feeling down, depressed or hopeless Not at all Several days More than half the days Nearly daily

Do you work? Yes No Retired

Do you have a Living Will/Durable Power of Attorney? Yes No

How many children do you have? _____

Personal and Family History Unknown/Adopted

(Check all that apply)

Circle any items that were known cause of death for relative

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
ADD/ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Alzheimer's Disease/Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Atrial fibrillation	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
BPH (enlarged prostate)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Blood disease (vists to hematology)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Cancer(s):			
Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Lung	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Prostate	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
CVA (Stroke or TIA)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Colon problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
COPD (emphysema)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Coronary artery disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Developmental Delay	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Gall Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Gallbladder disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
GERD	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Glaucoma/Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hearing deficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Heart disease/problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
before age 40 (male)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
before age 50 (female)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hyperlipidemia (high cholesterol)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Hypertension (high blood pressure)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Injuries:			
Concussion or head injury	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Car/motorcycle accident injury	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Ever been knocked unconscious	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Broken bones?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Which ones?			
Any other injuries:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
Irritable bowel disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Kidney stones	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Learning disability	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Migraines/headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Peptic ulcer disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Peripheral vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Seizure disorder/Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
OTHER (please list)			
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____

Have you had the following illnesses or vaccines?

Check all that apply

Date

<input type="checkbox"/> Hepatitis A	_____
<input type="checkbox"/> Hepatitis B	_____
<input type="checkbox"/> HPV (Gardasil)	_____
<input type="checkbox"/> Influenza	_____
<input type="checkbox"/> Last tetanus vaccination	_____
<input type="checkbox"/> Pneumonia (Pneumovax)	_____
<input type="checkbox"/> Pneumonia (Prevnar)	_____
<input type="checkbox"/> Shingles shot (Zostavax)	_____

FOR WOMEN ONLY

How many: Pregnancies _____ Live births _____

Menstrual History:

Age when menstrual period began _____

Do you use any form of birth control? Yes No

If yes, what? _____

First day of last menstrual period _____

Screening Tests Date

Last pap smear: _____

Any abnormal pap smears and/or cervical procedures?

Yes No If yes, indicate results and date.

Mammogram: _____

Any abnormal mammograms?

Yes No If yes, indicate results and date.