Specialists in Prevention Diagnosis and Treatment of Adult Illness

NEW PATIENT FORM

Name: ____ Date: ________________________

Date of Birth: ____

Medication: List all current medication and non-prescription medications, vitamins and herbal products. Please include medication taken occasionally such as Tylenol, Aspirin or Anti-inflammatory.

Name of Medication(s):	Dosage:	Frequency Taken:

Supplements:	Dosage:	Frequency Taken:

Allergies: Please include all allergies such as medication and/or medical supplies (i.e.: latex, iodine or tape).

Name of Medication/Product:	Reaction:

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Name: ____ Date: ____________________________

Date of Birth: ____

Surgical History:

Type of Surgery and Reason: Year:

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

Past Medical History: (active or inactive) Check those that are applicable

- □ CVA (stroke)
- □ TIA (mini stroke)
- □ Seizure
- □ Parkinson's
- □ Alzheimer's
- □ Memory Loss
- □ Headache/Migraine
- □ Angina (chest pain)
- □ Congestive Heart Failure
- □ Heart Value Disease
- □ Abnormal Heart Rhythm
- □ High Blood Pressure
- □ High Cholesterol
- □ Blood Clots/DVT
- □ Coronary Artery Disease
- □ Coronary Artery Stent/Bypass
- □ Stomach Ulcers
- □ Irritable Bowel Syndrome
- □ GERD, Reflux
- □ Gallstones
- □ Diverticulitis
- □ Liver Disease/Hepatitis
- □ Pancreatitis
- □ Colon Polyps
- □ Asthma/Bronchitis
- □ COPD/Emphysema
- □ Emphysema
- □ Tuberculosis
- □ Sleep Apnea
- □ Kidney Disease
- □ Kidney Stones
- □ Reoccurring UTI's
- □ Bleeding Disorder
- □ Cancer (Type): ____
- □ Thyroid Disease
- □ Diabetes
- □ Obesity
- □ Osteoporosis
- □ Osteoarthritis
- □ Rheumatoid Arthritis
- □ Fibromyalgia
- □ Gout
- □ Lupus
- □ Anxiety
- □ Depression
- □ Bipolar Disorder
- □ Alcoholism/Substance Abuse
- □ Psychiatrist/Psychologist
- □ Irregular Periods
- □ Menopause/Age
- □ Glaucoma
- □ Cataracts
- □ HIV/AIDS

Comments/Other:

____

____

____

____

____

____

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Name: ____

Date: ___________________________

Date of Birth: ____

Social History:
□ Married
□ Single
□ Widowed
□ Divorced

Children: □ Yes □No
Sons: #_______ Age(s): ________
Daughters: #_______ Age(s): ________

Occupation: ____

Education: ____

Do you exercise: □Yes □No
If so, how often/type? ___________
____

Do you drink alcohol? □Yes □No
If so, how many drinks per week?

Do you use tobacco?
How many cigarettes/pks per day?
Have you ever smoked? □Yes □No
How long:

When did you quit?

Do you currently use recreational drugs?
____

Advanced Directives:

Living Will: □ Yes □ No
Power Attorney: □ Yes □ No

Family Health History:

Father: □ Living □ Deceased | Age: ______ Medical Problems: ____
Mother: □ Living □ Deceased | Age: ______ Medical Problems: ____
Brother(s): □ Living □ Deceased | Age(s): __________ Medical Problems: _________________________________
Sister(s): □ Living □ Deceased | Age(s): __________ Medical Problems: __________________________________

Health Maintenance:

	Date:		Date:
Tetanus Vaccine:	__________________	Eye Exam:	__________________
Pneumonia Vaccine:	__________________	Mammogram:	__________________
Shingles Vaccine:	__________________	Bone Density:	__________________
Influenza Vaccine:	__________________	Pap smear:	__________________
Prostate Exam:	__________________	Skin Check:	__________________
Dental Exam:	__________________	Colonoscopy:	__________________
Cardiac Stress Test:	__________________	Carotid Ultrasound:	__________________

Abdominal Aortic Aneurysm (AAA) Screen: ____________________________________

Other Providers You See	Specialty
Name: ______________________________	______________________________
Phone Number: _______________________	
Name: ______________________________	______________________________
Phone Number: _______________________	
Name: ______________________________	______________________________
Phone Number: _______________________	

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