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Comprehensive New Patient Health History – Adult

Name _____ **Date of Birth** ___/___/_____ **Gender** ___

Did anyone assist you with completing this form? Yes/No **If yes, who?**_____

Current Medical Concerns (what you would like to talk about today):

1. (most important) _____
2. _____
3. _____

Have you received the following IMMUNIZATIONS (SHOTS?) ? If yes, then please try to indicate the approximate year it was given:

Influenza No ☐ Yes ☐ Year _____
Hepatitis A No ☐ Yes ☐ Year _____
Hepatitis B No ☐ Yes ☐ Year _____
Polio No ☐ Yes ☐ Year _____
Other (please specify) No ☐ Yes ☐ Year _____

Tetanus/Diphtheria No ☐ Yes ☐ Yr _____
Shingles Vaccine No ☐ Yes ☐ Yr _____
MMR (Measles/Mumps/Rubella) No ☐ Yes ☐ Yr_____
Pneumonia Shot No ☐ Yes ☐ Yr _____

Please list any ALLERGIES you have to medications:

NAME OF MED Reaction

_____

_____

Please list any MEDICATIONS that you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:

NAME OF MED Dose Directions (How often you take it)

_____

_____

_____

_____

Do you have DIFFICULTY performing any of these activities by YOURSELF?

Eating	No ☐	Yes ☐	Walking	No ☐	Yes ☐	Dressing	No ☐	Yes ☐
Bathing	No ☐	Yes ☐	Using Toilet	No ☐	Yes ☐	Housekeeping	No ☐	Yes ☐
Errands	No ☐	Yes ☐	Driving	No ☐	Yes ☐	Managing Money	No ☐	Yes ☐

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Family Health History

Are you adopted? Yes / No (If NO, please complete section below)

	Father	Mother	Grandmother	Grandfather	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism								
Aneurysm								
Anxiety or Depression								
Arthritis								
Asthma								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Manic-Depression or Bipolar								
Migraines								
MI = Heart Attack								
Osteoporosis								
Seizures								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

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Personal Health History

ADHD or ADD	No ☐	Yes ☐	Endometriosis	No ☐	Yes ☐
Allergies/Hay fever	No ☐	Yes ☐	Fibromyalgia	No ☐	Yes ☐
Anemia	No ☐	Yes ☐	Gout	No ☐	Yes ☐
Anesthesia Complications	No ☐	Yes ☐	GYN Problems	No ☐	Yes ☐
Anxiety Disorder or Recurrent Anxiety	No ☐	Yes ☐	HIV	No ☐	Yes ☐
Arthritis	No ☐	Yes ☐	Heart Problems	No ☐	Yes ☐
Asthma	No ☐	Yes ☐	Hepatitis C	No ☐	Yes ☐
Autism Spectrum Disorder	No ☐	Yes ☐	High Blood Pressure/Hypertension	No ☐	Yes ☐
Bipolar or Schizophrenia	No ☐	Yes ☐	High Cholesterol	No ☐	Yes ☐
Birth Defects or Inherited Disease	No ☐	Yes ☐	Kidney Stones	No ☐	Yes ☐
Blood Transfusion	No ☐	Yes ☐	Kidney or Bladder Problems	No ☐	Yes ☐
Cancer	No ☐	Yes ☐	Liver Disease	No ☐	Yes ☐
Chicken Pox	No ☐	Yes ☐	Migraines	No ☐	Yes ☐
Clotting Problems - Bleed too much or History of Blood Clots	No ☐	Yes ☐	Muscle, Joint, or Bone Problems	No ☐	Yes ☐
Depression	No ☐	Yes ☐	Osteoporosis	No ☐	Yes ☐
Developmental or Behavioral Disorders	No ☐	Yes ☐	Reflux/GERD	No ☐	Yes ☐
Diabetes or Pre-Diabetes	No ☐	Yes ☐	Seizures/Epilepsy	No ☐	Yes ☐
Diverticulitis/Diverticulosis	No ☐	Yes ☐	Skin problems (Rashes/Changing Moles)	No ☐	Yes ☐
Domestic Violence	No ☐	Yes ☐	Stomach Ulcers or Swallowing Problems	No ☐	Yes ☐
Ear Infections - Chronic	No ☐	Yes ☐	Stroke or TIA	No ☐	Yes ☐
Ear or Hearing Problems	No ☐	Yes ☐	Thyroid Problems	No ☐	Yes ☐
Eating Disorder like Anorexia or Bulimia	No ☐	Yes ☐	Tuberculosis or Positive TB Test	No ☐	Yes ☐
Eczema	No ☐	Yes ☐	Vision or Eye Problems	No ☐	Yes ☐
Emphysema/COPD/Chronic Bronchitis	No ☐	Yes ☐	Other: _____	No ☐	Yes ☐

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Have you ever had surgery? No ☐ Yes ☐
If YES, please list your surgeries (include the year if possible):

_____

_____

Have you stayed overnight in the hospital for other problems? No ☐ Yes ☐
If YES, please list them (include the year if possible):

_____

_____

Have you ever had any other serious injuries or broken bones? No ☐ Yes ☐
If YES, please list them (include the year if possible):

_____

_____

Have you had any of these TESTS? If yes, then please indicate when:

Colonoscopy No ☐ Yes ☐ Year _____ Bone Density Test No ☐ Yes ☐ Year _____
Pap Smear No ☐ Yes ☐ Year _____ Mammogram No ☐ Yes ☐ Year _____
Heart Testing/Stress Test No ☐ Yes ☐ Year _____

Social Health History

Relationship Status: Married / Divorced / Widow(er) / Single / Other Partner

What is your current living arrangement? House Apartment Care Home Other_____

Do you live: Alone With Spouse/Family With Others:_____

Do you feel safe at home? No ☐ Yes ☐

Is there somewhere else you feel unsafe? No ☐ Yes ☐

Do you have concerns about meeting basic needs (food/clothing/shelter?) No ☐ Yes ☐

Do you have have to follow a special diet? Yes/No **If Yes, describe:**_____

Education: What is your highest level of education? (What grade did you finish in school, or what degree after High School?) _____

Current Employment Status: Working / Unemployed / Retired / Intentionally Unemployed
Type of Work: _____

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Disability: Are you disabled? Yes / No _____

Incarceration: Have you ever been incarcerated? Yes / No _____

Do you Smoke? Yes / No **Do you use any other forms of Tobacco?** Yes / No

How many times in the past year have you had heavy alcohol consumption? (5+ drinks for men, 4+ for women in one day)?

Never 1 or more

How many times in the past year have you used an illegal drug OR used a prescription drug for non-medical reasons?

Never 1 or more

How do you think of your Overall Health? ❒ excellent ❒ good ❒ fair ❒ poor

Have you ever been diagnosed with Depression or Anxiety? No ☐ Yes ☐

During the past TWO WEEKS, have you often been bothered by of the following problems?

- Feeling down, depressed, irritable or hopeless? No ☐ Yes ☐
- Little interest or pleasure in doing things? No ☐ Yes ☐

WOMEN: Is there a chance you are pregnant? No ☐ Yes ☐

Have you been pregnant before? No ☐ Yes ☐ (How many times?) _____

When was your last menstrual period? _____

Is there anything else we have missed that you feel we should know about your health?

_____

_____

_____

_____

Thank you!