Today's Date _____

New Patient Health History

Name _____ DOB _____

Reason for Visit _____

Preferred Pharmacy _____

Primary Insurance _____

ALLERGIES □ None

ALLERGY	ALLERGIC REACTION

MEDICATIONS □ None

MEDICATIONS	DOSE	TAKE HOW OFTEN?

VACCINATION HISTORY

	DATE OF LAST
Tetanus Booster or Tdap	
Flu Vaccine	
Shingles Vaccine	
Pneumovax23 Vaccine	
Prevnar Vaccine	

HEALTH MAINTENANCE SCREENING TEST HISTORY

	DATE OF LAST
Abdominal Aortic Aneurysm (AAA)	
Colonoscopy	
PSA	
Mammogram	
Pap Smear	
Bone Density	

PAST ILLNESSES (Please circle)

Allergies	Crohn's or Colitis	Heart Disease	PTSD
Anemia	Depression/Anxiety	Heart Rhythm Problems	Reflux
Arthritis	Diabetes	High Cholesterol	Rheumatoid Disease
Asthma	Disc Disease/Back Pain	Hypertension	Seizures
Bipolar	Ear Infections	Hypothyroid	Skin Problems
Bladder Problems	Fibromyalgia	Insomnia	Sleep Apnea
Bleeding Problems	GI Bleeding	Irritable Bowel Syndrome	Stroke
Blood Clots	Glaucoma	Kidney Disease	Swelling
Cataracts	Gout	Osteoporosis	Ulcers
COPD	Headaches	Parkinson's Disease	

Other _____
_____
_____

SURGICAL HISTORY (Please circle)

Appendectomy	Cesarean Section	Hysterectomy	Tonsillectomy
Back Surgery	Gall Bladder	Knee Replacement	Tubal Ligation
Cardiac Bypass	Hernia	Prostate Surgery	Vasectomy
Cataracts	Hip Replacement	Thyroid Surgery	

Other _____
_____
_____

FEMALE HISTORY

Number of pregnancies	
Number of miscarriages/abortions	
Number of deliveries	
Number of living children & ages	
Age of first period	
Date of last menstrual period	
History of abnormal pap?	Y N If yes, date:

FAMILY HISTORY

	DIABETES	HYPER-TENSION	HEART DISEASE	STROKE	MENTAL ILLNESS	CANCER	OTHER
Father □ Living □ Deceased □ Unknown							
Mother □ Living □ Deceased □ Unknown							
Paternal Grandfather □ Living □ Deceased □ Unknown							
Paternal Grandmother □ Living □ Deceased □ Unknown							
Maternal Grandfather □ Living □ Deceased □ Unknown							
Maternal Grandmother □ Living □ Deceased □ Unknown							
Siblings □ Living □ Deceased □ Unknown							
Children □ Living □ Deceased □ Unknown							

SOCIAL HISTORY

ALCOHOL USE			
None	Rarely	Occasional	Daily

TOBACCO USE (if no, skip to Substance Abuse)			
Yes	No	Former	
TYPE			
Cigarettes	Cigars	Chewing Tobacco	E-cigarettes
Amount per day			
Number of years used			

SUBSTANCE ABUSE (if no, skip to Employment)		
Yes	No	Past
Type		
Number of years used		
Year stopped using		

SOCIAL HISTORY

EMPLOYMENT				
Full-time	Part-time	Retired	Student	Disabled

Do you work outside the home?	Yes No
Employer	
Position	

HOME/ENVIRONMENT	
Do you feel safe in your home?	Yes No
If no, type of abuse in home	Physical Mental Sexual
Do you have a safe place to go?	Yes No

MARITAL STATUS				
Single	Married	Widowed	Divorced	Separated

EXERCISE	
Do you exercise regularly?	Yes No
Type of exercise	
Duration of exercise	
Times/week	

SEXUAL ACTIVITY		
Yes	No	Previously
SEXUAL ORIENTATION		
Heterosexual	Homosexual	Bisexual

Condom use?	Yes No				
What do you use to prevent pregnancy?					
Have you ever been sexually abused?	Yes No				
Do you have a history of STI/STDs?	Yes No	If yes, please indicate:			
Gonorrhea	Chlamydia	Herpes	Trichamonas	Genital Warts	HPV
If you are 26 or younger, are you interested in the Gardasil vaccine (to prevent cervical cancer)?	Yes No				

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

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that people could have noticed. Or the opposite — being so fidgety or restless that you have been around a lot more than usual	0	1	2	3
9. Thoughts you would be better off dead, or of hurting yourself	0	1	2	3
(To be complete by healthcare professional)	Add columns			
	TOTAL			
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____