

NEW PATIENT HEALTH HISTORY

Name: _____

Date of Birth: _____

 Sex: Male Female

Gender Identity: _____

Employer: _____

Occupation: _____

 Highest Education Completed: High School/GED 2yr College 4yr College Post Graduate

Household members (spouse, children, parents, etc.): _____

 What is a goal that you have regarding your own health? *Nutrition, Physical Activity, etc.*

MEDICAL HISTORY

Place check mark beside each condition that you are being, or have been, treated for; comment as appropriate.

Sensory

- Vision Loss
- Glaucoma
- Cataracts
- Hearing Loss
- Tinnitus
- Loss of Taste/Smell

Respiratory

- Asthma
- COPD/Emphysema
- Recurrent Bronchitis
- Pneumonia
- Chronic Allergies

Cardiovascular

- Coronary Artery Disease
- Angina
- Arrhythmia
- Heart Failure
- Hypertension
- Hyperlipidemia
- Cardiac Procedure/Surgery

Gastrointestinal

- Heartburn/GERD
- Stomach/Small Bowel Ulcer
- IBS
- Inflammatory Bowel Disease
- Hemorrhoid
- Chronic Diarrhea/Constipation
- Colon Polyps

Endocrine

- Diabetes 1 or 2
- Gestational Diabetes
- Thyroid Disorder
- Adrenal Disorder
- Hormone Disorder

Musculoskeletal

- Arthritis
- Gout
- Spine Problem
- Muscle Condition
- Osteoporosis
- Lupus
- Rheumatoid Arthritis

Neurological

- Headache/Migraine
- Seizure
- Tremor
- Memory Loss
- Stroke
- Multiple Sclerosis

Skin

- Acne
- Eczema
- Psoriasis
- Nail Disorder
- Skin Cancer
- Melanoma

Mental Health

- Depression
- Anxiety
- Bipolar Disorder
- PTSD
- OCD
- ADHD
- Schizophrenia

Genitourinary

- Kidney Disease/Stones
- Bladder Condition
- Urinary Incontinence
- Prostate Disorder
- Recurrent Urinary Infection
- Sexual Dysfunction
- Sexually Transmitted Infection

Obstetric History (Female Only)

Menses Start Age: _____

 Regular Irregular

Menopause Age: _____

of Pregnancies: _____

of Live Births: _____

of Vaginal Deliveries: _____

of C-Section Deliveries: _____

Miscarriages/Terminations: _____

of D&C: _____

Cancer Type and Treatment: _____

Comments: _____

affix label here

SURGICAL HISTORY List any recent surgeries with date and place performed (include colonoscopy).

SOCIAL HISTORY

Exercise

What do you currently do for exercise? _____ Frequency: _____

Nutrition

Any current restrictive eating plan: _____ Weight Loss Medication: _____

Substances

Nicotine: Current Past Never Frequency (per day): _____

Type: Cigarettes Cigars Pipe Chew Vape

Alcohol: Current Past Never Type: Beer Wine Hard Liquor Drinks(per week): _____

Marijuana: Current Past Never Method of Use: _____ Frequency: _____

Kratom: Current Past Never

Mushrooms: Current Past Never Other Substances: _____

Cocaine: Current Past Never

Heroin: Current Past Never Needle Use: Yes No

Meth: Current Past Never DUI: Yes No

Recovering from Addiction: No Yes Treatment Type: _____

Sexual Life

Sexually Active: Yes No

Sexual Partner(s): Single Multiple Male Female Other: _____

Preventive Practice(s): Birth Control, Type: _____ Condoms/Barrier

Sexual Health Concerns: No Yes, Type: _____

Sleep

Restorative Sleep: Yes No

Snoring: Yes No

Consistent Sleep: Yes No

Sleep Aids: Yes No

Advanced Directive

Do you currently have an Advanced Directive? Yes No

FAMILY HISTORY

Complete the known medical history of genetic family.

Adopted: Yes No

Father: Deceased _____

Mother: Deceased _____

Siblings: Deceased _____

Grandparents: Deceased _____

Grandparents: Deceased _____

Other: _____

MEDICATIONS Bring all of your current medications and supplements with you for your appointment.

ALLERGIES

Are you allergic to any medications? No Yes; list medication(s) & reaction(s) _____

Do you have any concerns regarding adequate food, clothing, housing or transportation? Yes No

Do you feel safe in your home (physically/emotionally/sexually)? Yes No History of abuse? Yes No

List anything about your health that you think your provider should know:

Reviewed by: _____ Date: _____