

NEW PATIENT INFORMATION FORM

Patient's Name _____ Date _____

What is the reason for your visit today? _____

Who was your last primary care physician? _____

Please provide their Address/Phone/Fax: _____

Please list any specialists seen in the last five years:

Name	Specialty	Address

List all surgeries (along with the year):

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

List all medications you are currently taking including prescription drugs, OTC drugs, vitamins, minerals, and herbs:

Name of Medication	Dosage/Strength	How Often Taken

Have you ever had an allergic reaction to a medication? Yes _____ No _____ If yes, please list:

Medication/Reaction	Medication/Reaction
1. _____	3. _____
2. _____	4. _____

Do you smoke? Yes _____ No _____ # of years you have smoked? _____ # of packs/day? _____

If you quit smoking, when did you quit? _____ For how long did you smoke? _____ # of packs/day? _____

Do you drink alcohol? Yes ___ No ___ # of drinks in a day/week? _____ Type of drink? _____

Do you use recreational drugs? Yes ___ No ___ Types of drugs? _____

Any previous history of drug use? _____ Type of drugs _____ Year Quit _____

Any history of communicable illnesses/STDs?(please list) _____

Current Occupation (previous, if retired): _____

Please list your hobbies: _____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____ Same gender relationship _____

Number of Children: _____ Number of Step-Children _____

Please list members of your household:

Name/Age	Name/Age
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Do you have a current Living Will or Power of Attorney? (circle one) yes no

PREVENTIVE CARE	DATE	RESULTS
Bone Density Scan		
Mammogram		
Colonoscopy		
Pap		
Blood Work		
Podiatry/Foot Exam		
Eye Exam		
(Other)		

ADULT IMMUNIZATIONS	DATE OF YOUR LAST SHOT
Hepatitis B	
HPV/Gardasil	
Influenza	
Pneumococcal Pneumonia	
Tetanus/Diphtheria	
(Other)	

Personal and Family History of Illnesses:

	Patient's History	Circle family members who have had each illness
Alcoholism	Past / Present	Mother/ Father/ Sister/ Brother/ Pat GM/ Pat GF/ Mat GM/ Mat GF/Aunt/ Uncle
Allergies	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Anxiety	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Anemia	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Arthritis (Osteo)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Asthma	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Bipolar Disorder	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Blood Clots (where)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Cancer (type)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
COPD/Emphysema	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Dementia/Alzheimer's	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Depression	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Diabetes	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Drug Abuse	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Erectile Dysfunction	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
GERD (heartburn)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Gout	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Heart Disease/CAD	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Heart Failure (CHF)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Hepatitis (circle: A / B / C)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
High Blood Pressure	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
High Cholesterol	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
HIV/AIDS	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Hypothyroidism (low thyroid)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Hyperthyroidism (high thyroid)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Kidney Disease	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Kidney Stones	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Lupus	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Osteoporosis	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Pneumonia	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Prostate Enlargement	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Rheumatoid Arthritis	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Seizures	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
Stroke	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
TIA/Mini-Stroke	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U
(Other)	Past / Present	M / F / S / B / PGM / PGF / MGM / MGF / A / U