New Patient Health History – Adult

Name _____ **Date of Birth** _____ **Today's Date** _____

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

1. (most important) _____

2. _____

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 (please write on back of page if needing additional space):
Name of Med Dose Directions (How often you take it)

_____

_____

_____

_____

Have you received the following immunizations (shots)? If yes, please indicate the approximate year received:
Flu Shot: ❒ Yes ❒ No Year_____Tetanus/Diphtheria: ❒ Yes ❒ No Year___Hepatitis A: ❒ Yes ❒ No Year___
Shingles: ❒ Yes ❒ No Year ___ Pneumonia Shot: ❒ Yes ❒ No Year ___ Hepatitis B: ❒ Yes ❒ No Yr___
MMR: ❒ Yes ❒ No Year ___ Polio: ❒ Yes ❒ No Year ___ Other: _____❒ Year_____

WOMEN: Is there a chance you are pregnant? ❒ Yes ❒ No
Have you been pregnant before? ❒ Yes ❒ No (How many times?) _____
When was your last menstrual period? _____

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

_____

Any hospitalizations? ❒ Yes ❒ No If YES, please list them (include the year if possible):

_____

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

_____

Have you had any of these TESTS? If YES, please indicate when:
Colonoscopy: ❒ Yes ❒ No Year _____Bone Density Test: ❒ Yes ❒ No Year _____
Pap Smear: ❒ Yes ❒ No Year _____ Mammogram: ❒ Yes ❒ No Year _____
Heart Testing/Stress Test: ❒ Yes ❒ No Year _____

FAMILY HEALTH HISTORY

Are you adopted? ❒ Yes ❒ No (If NO, please complete section below) P=Paternal M=Maternal

	Mother	Father	Grandma	Grandpa	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism/Substance Abuse								
Aneurysm								
Anxiety and/or Depression								
Arthritis								
Asthma								
Bipolar or Schizophrenia								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Heart Attack								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Migraines								
Osteoporosis								
Seizures/Epilepsy								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

PERSONAL HEALTH HISTORY

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