If extra space is needed for a particular question, please feel free to attach additional paper to answer.

Date of New Patient Appointment:

Patient Name: _____
Last First Middle Initial

Preferred Name:

DOB:

Preferred Pronoun/Gender:

Current and Previous Physicians (Past 10 Years) Please list physician's name AND specialty	**Current Medications** Please list medication, dose and frequency
Allergy History (e.g. to dairy products, eggs, nuts, pollen, etc) Please list with allergic reaction	**Medication Allergies** Allergic reactions to medications? If so, please list the medication and reaction

SOCIAL HISTORY

Marital Status: □Single □Single in a relationship □Married □Separated □Divorced □Widowed

Number of Children:

Occupation:

Belief or Religion:

Do you have an **Advanced Health Care Directive** or a living will?
□ Yes, I have one completed
□ No, but I am currently working on it
□ No, not at all

Do you have a **Durable Power of Attorney**? □Yes □No
If so, who is it? _____

Smoking Status: □Never Smoker □Current Some Day Smoker □Current Every Day Smoker □Former Smoker

If you are a current or former smoker, please answer the following:

Smoking:
□Cigarettes □Cigars □Pipes □Other: Packs/ Day:
Start date: Quit date:

Have you ever used smokeless tobacco? □Yes □No
Types: □Snuff □Chew □Other:
Start date: Quit date:

Vaping Status: □Never Smoker □Current Some Day Smoker □Current Every Day Smoker □Former
How many times a day? How many times a week?
Start date: Quit date:

Alcohol Use: □Yes □Not Currently □Never

If you have current alcohol use or used to in the past, please answer the following:

Types:
□Wine □Beer □Shots of liquor □Other:

How often do you have a drink containing alcohol?
□Never □Monthly or less □2-4 times a month
□2-3 times a week □4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?
□ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more

Any recreational drug use (e.g. marijuana)? □Never □Current Some Day □Current Every Day □Former User
Types: How often:

Any current exercising habits? □Yes □Not Currently □No
Type of exercise: How often and for how long:

Any caffeine? □Yes □Not Currently □No
If so, what type and how often:

Any special diet? □Yes □Not Currently □No
If so, please specify: Start date: End date:

Sexually Active: □Yes □Not Currently □Never
Partners: □Female □Male □Both female and male
Birth Control/Protection: □Not applicable □None □Condom □Pill □ IUD □Abstinence □Partner Vasectomy □Other (please specify):

FAMILY HISTORY (Please list medical conditions such as. high blood pressure, high cholesterol, diabetes, mental health conditions, cancer)	
Mother:	Father:
Brother/Sister:	Children:
Maternal Grandmother:	Maternal Grandfather:
Paternal Grandmother:	Paternal Grandfather:
Other family members (maternal/paternal uncle and aunt, cousin):	

PAST MEDICAL HISTORY (Please circle any applicable medical conditions)
☐Stroke ☐TIA (Transient Ischemic Attack) ☐Seizure ☐Migraines ☐Memory disorder ☐Multiple sclerosis ☐Parkinson's disease
☐Heart attack ☐Heart disease ☐Heart failure ☐Heart murmur ☐Abnormal heart rhythms ☐High blood pressure ☐High cholesterol ☐Pacemaker ☐Implantable defibrillator
☐Asthma ☐COPD ☐Cystic fibrosis ☐Bronchiectasis ☐Pneumonia ☐Tuberculosis ☐Pulmonary fibrosis ☐Interstitial lung disease ☐Sleep apnea
☐Heartburn ☐Ulcers ☐Liver problem ☐Hepatitis ☐Gallstones ☐Pancreatitis ☐Irritable bowel syndrome ☐Inflammatory bowel disease ☐Hemorrhoids
☐Kidney problems ☐Kidney stones ☐Frequent UTIs ☐Heavy menses ☐Enlarged prostate ☐Erectile dysfunction ☐Urinary incontinence ☐Anemia ☐Abnormal blood counts ☐Blood clots
☐Diabetes ☐Thyroid disease ☐Osteopenia/Osteoporosis
☐Arthritis ☐Gout ☐Falls
☐Glaucoma ☐Cataracts ☐Macular degeneration ☐Hearing loss ☐Tinnitus ☐Vertigo
☐Cancer (please specify):
☐Autoimmune conditions (please specify):
☐HIV/AIDS ☐Sexually Transmitted Infections (please specify): ☐Abnormal pap smears (Date:)
☐Skin conditions (please specify):
☐Positive TB test Have you been treated? ☐ No ☐ Yes, treated with: ☐Last chest x-ray date and location:
☐Blood transfusions
☐Depression ☐Anxiety ☐Mental health conditions (please specify):

IMMUNIZATIONS (It is helpful to bring in your immunization records to your first visit)

Immunizations/ Vaccines		Date Administered	Location of Administration (Name of pharmacy or physician's office)
Influenza (Flu Shot)			
Tetanus	Td		
	Tdap		
Pneumonia Vaccine	Prevnar 13		
	Pneumovax 23		
Shingles Vaccine	Zostavax		
	Shingrix (1st dose)		
	Shingrix (2nd dose)		
Hepatitis B			

HEALTH MAINTENANCE (When did you last have the following tests?)		
	Date	Physician who performed or ordered the exam
Last Full Physical Exam		
Dental Exam		
Eye Exam		
Cholesterol Screening		
Diabetes Screening		
STI Screening		
Hepatitis C Screening		
HIV Screening		
Pap Smear		
Mammogram		
Colonoscopy		
Endoscopy		
Sigmoidoscopy		
Stool Card Testing for Blood (FOBT / Cologuard)		
DEXA (Bone Density Scan)		
Low-dose Lung CT Scan for lung cancer screening (for current and previous smokers)		

HOSPITALIZATION HISTORY		
Reason	Year	Hospital

SURGICAL HISTORY		
Surgery	Year	Hospital and Physician