ADULT HISTORY NEW PATIENT FORM

PLEASE BRING ALL MEDICATION(S) TO YOUR APPOINTMENT.

Please complete this form and bring it with you to your visit.

Date: _____

Name: _____ Date of Birth: _____

(Last) (First) (Middle)

Birth Sex: ☐ Male ☐ Female ☐ Undifferentiated **Current Gender Identity:** ☐ Choose not to disclose ☐ Female ☐ Female-to-Male/Transgender Male ☐ Genderqueer ☐ Male ☐ Male-to-Female/Transgender Female

Preferred Pronoun: ☐ Decline to answer ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other _____

☐ Single ☐ Married ☐ Widow(er) ☐ Partner ☐ Divorced **Who do you live with?** ☐ Alone ☐ Partner ☐ Family ☐ Other

Email: _____ Would you like to enroll in the Patient Portal? ☐ Yes ☐ No

Occupation: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Insurance: _____ Policy Number: _____

Having race, ethnicity and language information for all of our patients helps us know them better.

Race: ☐ Alaskan Native or American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Other _____ ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Declined

Are there any other languages spoken in the home? If yes, please list:

_____

Preferred Pharmacy: _____

Address: _____

Phone: _____ Fax: _____

☐ **Routine Check Up — No Symptoms**

Reason for Visit: *(please list all current symptoms)*

1. _____
2. _____
3. _____

Chronic Problems:

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

Do you take your medications as directed? ☐ Yes ☐ No

***Please bring all medications to your visit in a bag.**

Name of Medication	Dosage	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		

Supplements / Herbs / Over the counter medication:

1. _____
2. _____

Allergies:

Source	Reaction	Source	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever had any of the following?

(If yes, enter date to those that apply)

TEST	Date
Eye Exam	
Dental Exam	
Cholesterol	
PPD (TB test)	
HIV test	
Hepatitis C	
Stool blood test	
Colonoscopy	
Bone density	
Chest X-Ray	
Heart Stress Test	
Blood transfusion	
MRI	
Sleep Study	
Other	

Surgical History	Date
Angioplasty	
Appendectomy	
Arthroscopy of knee	
Back surgery	
CABG (Heart bypass)	
Carpal tunnel release	
Cataract extraction	
Colon resection	
Colostomy	
Defibrillator	
Fracture	
Location:	
Gallbladder out	
Gastric bypass	
Gastric Band	
Gastric Sleeve	

Surgical History	Date
Heart Valve	
Hernia repair	
Hip/Knee replacement	
Hysterectomy	
Why did you have a hysterectomy?	
Was your cervix removed? ☐ Yes ☐ No	
Were your ovaries removed? ☐ Yes ☐ No	
Did you have a vaginal hysterectomy? ☐ Yes ☐ No	
LASIK	
Mastectomy	
Small bowel resection	
Thyroidectomy	
Tonsillectomy	
Pacemaker	
Prostate surgery	
Other	

Other recent physician or hospital visits:

1. _____ **2.** _____ **3.** _____

Social History *(Check all that apply)*

Alcohol Use ☐ Yes ☐ No ☐ Former

Years Drinking _____

Drinks per week _____

Type _____

Quit date _____

Last drink _____

Caffeine ☐ Yes ☐ No Amount/week

Coffee _____

Pop/Soda _____

Energy drinks _____

Other: _____

Exercise ☐ Yes ☐ No

Frequency (Hours/week): _____

Types:

Tobacco ☐ Yes ☐ No ☐ Former

☐ Cigarettes

Packs per day _____

☐ Cigars

☐ Chewing Tobacco

☐ Would like to quit

Years of use _____

Year quit _____

Sexual History

Are you currently sexually active?

☐ Yes ☐ No

Any history of sexually transmitted diseases?

☐ Yes ☐ No

If yes, when?

Recreational drug use

☐ Yes ☐ No ☐ Former

Have you ever used IV drugs?

☐ Yes ☐ No

Personal safety

Do you wear your seatbelt?

☐ Yes ☐ No

Do you have difficulty dressing yourself?

☐ Yes ☐ No

Do you have difficulty carrying 10 pounds?

☐ Yes ☐ No

Do you have difficulty shopping?

☐ Yes ☐ No

Other

Have you experienced a fall in the last year? ☐ Yes ☐ No If yes, how many times have you fallen this year?_____

Were you injured in the fall(s)? ☐ Yes ☐ No

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

Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Feeling down, depressed or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Do you work? ☐ Yes ☐ No ☐ Retired

Do you have a Living Will/Durable Power of Attorney? ☐ Yes ☐ No

How many children do you have? _____

Personal and Family History

☐ Unknown/Adopted

(Check all that apply)

Circle any items that were known cause of death for relative

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
ADD/ADHD	☐ Yes	☐ Yes	
Alcoholism	☐ Yes	☐ Yes	
Allergies	☐ Yes	☐ Yes	
Alzheimer's Disease/Dementia	☐ Yes	☐ Yes	
Anemia	☐ Yes	☐ Yes	
Angina	☐ Yes	☐ Yes	
Anxiety	☐ Yes	☐ Yes	
Arthritis	☐ Yes	☐ Yes	
Asthma	☐ Yes	☐ Yes	
Atrial fibrillation	☐ Yes	☐ Yes	
BPH (enlarged prostate)	☐ Yes	☐ Yes	
Blood clots	☐ Yes	☐ Yes	
Blood disease (vists to hematology	☐ Yes	☐ Yes	
Cancer(s):			
Breast	☐ Yes	☐ Yes	
Colon	☐ Yes	☐ Yes	
Lung	☐ Yes	☐ Yes	
Prostate	☐ Yes	☐ Yes	
Other:	☐ Yes	☐ Yes	
CVA (Stroke or TIA)	☐ Yes	☐ Yes	
Colon problems	☐ Yes	☐ Yes	
COPD (emphysema)	☐ Yes	☐ Yes	
Coronary artery disease	☐ Yes	☐ Yes	
Depression	☐ Yes	☐ Yes	
Developmental Delay	☐ Yes	☐ Yes	
Diabetes	☐ Yes	☐ Yes	
Eczema	☐ Yes	☐ Yes	
Gall Stones	☐ Yes	☐ Yes	
Gallbladder disease	☐ Yes	☐ Yes	
GERD	☐ Yes	☐ Yes	
Glaucoma/Cataracts	☐ Yes	☐ Yes	
Hearing deficiency	☐ Yes	☐ Yes	
Heart disease/problems	☐ Yes	☐ Yes	
before age 40 (male)	☐ Yes	☐ Yes	
before age 50 (female)	☐ Yes	☐ Yes	
Hemorrhoids	☐ Yes	☐ Yes	
Hernia	☐ Yes	☐ Yes	
Hepatitis C	☐ Yes	☐ Yes	
Hyperlipidemia (high cholesterol)	☐ Yes	☐ Yes	
Hypertension (high blood pressure)	☐ Yes	☐ Yes	
Injuries:			
Concussion or head injury	☐ Yes	☐ Yes	
Car/motorcycle accident injury	☐ Yes	☐ Yes	
Ever been knocked unconscious	☐ Yes	☐ Yes	
Broken bones?	☐ Yes	☐ Yes	
Which ones?			
Any other injuries:	☐ Yes	☐ Yes	

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
Irritable bowel disease	☐ Yes	☐ Yes	
Kidney disease	☐ Yes	☐ Yes	
Kidney stones	☐ Yes	☐ Yes	
Learning disability	☐ Yes	☐ Yes	
Liver disease	☐ Yes	☐ Yes	
Lupus	☐ Yes	☐ Yes	
Mental illness	☐ Yes	☐ Yes	
Migraines/headaches	☐ Yes	☐ Yes	
Obesity	☐ Yes	☐ Yes	
Osteoarthritis	☐ Yes	☐ Yes	
Osteoporosis	☐ Yes	☐ Yes	
Peptic ulcer disease	☐ Yes	☐ Yes	
Peripheral vascular disease	☐ Yes	☐ Yes	
Psoriasis	☐ Yes	☐ Yes	
Rheumatoid Arthritis	☐ Yes	☐ Yes	
Seizure disorder/Epilepsy	☐ Yes	☐ Yes	
Sleep Apnea	☐ Yes	☐ Yes	
Thyroid disease	☐ Yes	☐ Yes	
OTHER (please list)			
_____	☐ Yes	☐ Yes	
_____	☐ Yes	☐ Yes	

Have you had the following illnesses or vaccines?

Check all that apply — **Date**

- ☐ Hepatitis A _____
- ☐ Hepatitis B _____
- ☐ HPV (Gardasil) _____
- ☐ Influenza _____
- ☐ Last tetanus vaccination _____
- ☐ Pneumonia (Pneumovax) _____
- ☐ Pneumonia (Prevnar) _____
- ☐ Shingles shot (Zostavax) _____

FOR WOMEN ONLY

How many: Pregnancies _____ Live births _____

Menstrual History:

Age when menstrual period began _____

Do you use any form of birth control? ☐ Yes ☐ No

If yes, what? _____

First day of last menstrual period _____

Screening Tests — **Date**

Last pap smear: _____

Any abnormal pap smears and/or cervical procedures?

☐ Yes ☐ No If yes, indicate results and date.

Mammogram: _____

Any abnormal mammograms?

☐ Yes ☐ No If yes, indicate results and date.

Patient Signature: _____ Date Signed: _____