Innovative Family Care

New Patient Health History

Name: _____

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

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Reason for visit?

_____

_____

Which Pharmacy do you use? _____ Location? _____

Home and Family

If female, number of children born Living: ____ Stillborn: ____ Miscarriages: ____

Who lives with you? _____

Job Status: ☐ Working Occupation: _____ Employer: _____
☐ Student ☐ Unemployed ☐ Retired ☐ Disabled From occupation: _____

If under age 18 or not adult status:

Mother's Name _____ Father's Name_____

Who is legal guardian?_____

Highest Education Level Completed: ☐ Grade school ☐ High school ☐ College ☐ Graduate degree

Special needs/services required:_____

Hobbies/Extracurricular activities: _____

Dwelling structure: ☐ House ☐ Apt /Condo ☐ Trailer ☐ Dorm ☐ Assisted Living – facility? _____

Spiritual

Faith/religion: _____ Congregation/place of attendance: _____

Lifestyle

Do you? If yes, how much?

Smoke tobacco: ☐ Yes _____ packs per day or ____ cigarettes/cigars per day
☐ Former ☐ Never

E-Cigs/Vape ☐ No ☐ Yes

Chew tobacco ☐ No ☐ Yes ___ tins/pouches per day

Drink caffeine ☐ No ☐ Yes ___ drinks per day

Drink alcohol ☐ No ☐ Yes ___ drinks per day

Use street drugs ☐ No ☐Yes Type? _____

Exercise: ☐ No ☐ Yes Type/Frequency?_____

Health History

Who is/was your previous primary care physician? _____

What other specialists are you currently seeing or have seen recently? _____

Childhood Illnesses (Circle the diseases you had)

Chicken Pox	Mononucleosis	Rheumatic Fever
Chronic ear infections	Mumps	Scarlet Fever
Diphtheria	Pertussis	Strep Throat
Measles	Polio	
Meningitis		

Medical Problems (circle the problems you have; give any additional details below each section)

Endocrine/Metabolic: Diabetes, Polycystic Ovary Syndrome, Thyroid Problem, High Cholesterol, Osteoporosis, Low Testosterone, Menopause

Eyes, Ears, Nose, Throat: Cataracts, Glaucoma, Retinopathy, Hearing Loss, Tinnitus

Cardiovascular: Hypertension, Coronary Artery Disease, Heart Attack, Stents, Bypass Surgery, Congestive Heart Failure, Heart Murmur, Peripheral Vascular Disease (PVD), Cerebrovascular Disease, Stroke, TIAs, Carotid Artery Disease, DVT, Blood Clots to Lung or Leg, Venous Insufficiency

Respiratory: COPD of Emphysema, Asthma, Chronic Bronchitis, Sleep Apnea, Pulmonary Fibrosis, Pneumonia

Gastrointestinal: GERD, Peptic Ulcer Disease, Irritable Bowel Syndrome, Crone's Disease, Ulcerative Colitis, Constipation, Diarrhea, Hemorrhoids, Cirrhosis, Pancreatitis

Genitourinary: BPH, Incontinence, IC, Recurrent UTI, ED, Hernia

Obstetrical/GYN: Contraception, Problems in Pregnancy, Endometriosis, Dropped Bladder

Musculoskeletal: Osteoarthritis, Degenerative Joint Disease, Bulging Discs, Chronic Injuries, Plantar Fasciitis, Carpal Tunnel, Contractures, Scoliosis, Fracture

Renal: Chronic Kidney Disease, Kidney Stones

Neurologic: Seizures, Neuropathy, Deficits from CVA, Tremors, Parkinson's, Alzheimer's, Dementia, Restless Legs, Reflex Sympathetic Dystrophy, Multiple Sclerosis, Muscular Dystrophy

Allergy/Immune/Rheum: Allergies, Rheumatoid Arthritis, Lupus, Psoriasis

Malignancy: Lung, Breast, Colon, Skin, Brain, Cervical, Ovarian, Prostate, Endometrial, Pancreatic, Throat

Dermatology: Acne, Rosacea, Vitiligo, Eczema

Infectious Diseases: Hepatitis, HIV, AIDS, Herpes, HPV, Tuberculosis, Lyme Disease

Mental Health: Depression, Anxiety, Bipolar, Schizophrenia, Schizoaffective Disorder, Addiction

Hospitalizations (not including normal pregnancies) **Year**

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

Surgeries (circle all that apply and list year)

C-section	Gall Bladder Removal	Heart:	Other _____
Hysterectomy	Bladder Suspension	Catheterization	
Ovary/Uterus	Hip Replacement	Angioplasty	
Appendectomy	Knee Replacement	Bypass/Stents	

If female, date of last menstrual period: _____ Age at onset: _____ Freq: _____ days Duration: _____ days

Health Maintenance History (please indicate date of last exam/test)

	Date		Date		Date
Complete Physical Exam		Pneumonia Vaccine		Gardasil (HPV) Vaccine	
Colonoscopy		Shingles Vaccine		Bone Density Scan (DEXA)	
Eye Exam		Tetanus		EKG	
Influenza Vaccine		Chest X-Ray		Rectal Exam	
Mammogram		Dental Exam		PSA Test (Prostate Blood Test)	
Pap Smear		TB Test			

OVER-THE-COUNTER Medications:

Circle any *over the counter* herbs, vitamins, supplements, etc. you are currently taking:

Laxatives	Vitamins	Antacids
Pain Relievers	Energy Drinks/Pills	Weight Loss Pills

Other: _____

PRESCRIBED Medications (use back of page for additional)

Medication	Dose/Freq	Medication	Dose/Freq

Medication Allergies:

_____

_____

Food Allergies: ☐ no ☐ yes If yes, what foods: _____

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if living)									
Current Health									
Age at death (if applicable)									
Cause of Death									
Conditions (check all that apply)									
Cancer (type)									
Diabetes									
Epilepsy									
Heart Disease									
High Blood Pressure									
Stroke									
Kidney Disease									
Mental Illness									
Alcohol Abuse									
Drug Addiction									
Alzheimer's									
TB									
Athritis									
Glaucoma									
Anemia									