



New Patient & Family History

Today's Date: _____ Patient Name: _____ Date of Birth: _____
Last First Middle or Maiden

Gender: Male Female Marital Status: (Please check one) Married Single Divorce Widow Other: _____

Telephone (1st call): (____) _____ Telephone (2nd call): (____) _____

Referring Physician: _____
Name Address City State Zip Code

Primary Care Physician: _____
Name Address City State Zip Code

Number of Children: _____ Ages: _____

What is your primary language? _____

Who lives with you? (Please check all that apply) I live alone Spouse Children Parents Friend Other: _____

Who helps at home? _____

Person(s) with your Medical Record Access: _____
Name Relationship Telephone

Have you executed a Durable Power of Attorney, Directive to Physician and/or Living Will? Yes No
Would you like additional information regarding these documents? Yes No

If you have signed one of these legal documents then please speak to the nurse regarding your decisions and bring a copy with you to your appointment

Do you have daily transportation available? Yes No

I am currently: Working: Yes No Work Schedule is: Full-time Part-time Sick Leave Retired Disability

What type of work do you currently do or have done? _____

Do you use any of the following? (Please check all that apply)

Alcohol: Yes No What type? _____ How much? _____ How often? _____ If quit, when? _____

Tobacco: Yes No What type? _____ How much? _____ How often? _____ If quit, when? _____

Caffeine: Yes No What type? _____ How much? _____ How often? _____ If quit, when? _____

Recreational Drugs: Yes No What type? _____ How much? _____ How often? _____ If quit, when? _____

Sunscreen: Yes No

How much time do you spend exercising each week? _____ What type of exercise? _____

Do you need to use any of the following? (Please check all that apply) Cane Walker Wheelchair Oxygen
 Other: _____

Do you do monthly self-exams? (Please check all that apply) Skin cancer: Skin Mole Other: _____

Female: Breast Yes No Have you ever been trained properly for breast self-exam? Yes No

Male: Testicles Yes No Have you ever been trained properly for testicular self-exam? Yes No

Are you diabetic? Yes No If yes, what type: _____

If yes, how is it controlled: Diet Oral Medications Insulin Other: _____

Are you claustrophobic (fearful of being in enclosed or narrow spaces): Yes No If yes, how is it controlled: _____

Reproductive History:

Female: Number of pregnancies: _____ Number of children: _____ Age at first pregnancy: _____

Did you breast feed: Yes No If yes, how many months (approximate): _____

Age at first period: _____ Age at menopause: _____ Age at last period: _____

Hysterectomy: Yes No Ovaries intact: Yes No If no, please explain: _____

Hormone use: Yes No Sex Drive: Yes No Method of birth control: _____

Male: Impotence (Erectile Dysfunction): Yes No Sex Drive: Yes No



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What is your understanding of why you are being seen: _____

Additional Medical Condition History

(If additional space is needed then please copy this page)

Diagnosis / Condition	Physician Name	Physician Office #	Date Occurred

Surgery / Injury / Hospitalization	Physician Name / Hospital	Physician Office #	Date Occurred

Please list the names of hospital(s) or clinic(s) where you had x-rays in the last six months: _____

Preventive Health Maintenance

(Please provide dates for each or answer "none")

Female: Last mammogram: _____ Last bone density scan: _____
 Last pap smear: _____ Last pneumonia vaccine: _____
 Last colonoscopy: _____

Male: Last colonoscopy: _____ Last PSA screening: _____
 Last prostate exam: _____ Last pneumonia vaccine: _____

Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below

(M) = Maternal (P) = Paternal (If additional space is needed then please copy this page)

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		Grandmother (P)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Father	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		Grandfather (P)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Children	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		Aunt(s)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Brother(s)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		Uncle(s)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Sister(s)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		Cousin(s)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	
Grandmother (M)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		Other:		
Grandfather (M)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		Other:		

Patient Signature: _____ Date: _____

If someone other than the patient completed this form, please give name & relationship: _____
Name Relationship

Nurse Name: _____ Signature: _____ Date Reviewed: _____