New Patient Information (Adult)

Name:_____DOB:_____/_____/_____Date:_____/_____/___
Preferred name: _____

1. List the medicines you are currently taking:

Medication/dose/times per day	Medication/dose/times per day	Medication/dose/times per day

Preferred Pharmacy: _____

List any allergies you have and describe reaction:

Check if you have or have had any of the following illnesses:

	Rheumatic Fever		Pneumonia		Cancer		Tuberculosis
	Heart Trouble		Emphysema		Menstrual Problems		Glaucoma
	High Blood Pressure		Ulcers		Stroke		Colitis
	Asthma		Hepatitis		Epilepsy / Convulsions		Blood Clots
	Hay Fever		Urinary Tract Problems		Anxiety / Depression		Sexual Problems
	Diabetes		Venereal Disease		Skin Problems		Thyroid Problems
	Anemia		Arthritis		H.I.V.		
	Other (specify)						

2.

Surgery, Injury, or Reason for hospitalization	Year or Age	Hospital	Doctor's Name

3. Social Habits and Preventive Health History (check box)**:**

	Alcohol Consumption			**Tobacco Usage**	**Seat Belt Usage**	**Last Colonoscopy**
	Never			Cigarettes	Always	Date:
	Very Occasional			Cigars	Sometimes	**Last Prostate Test**
	Occasional			Chewing Tobacco	Never	Date:
	Moderate		Heavy	Vape	**Exercise**	**Last Dexa Scan**
	Weekends		Social	Age Began:	Times Weekly	Date:
	Recovering Alcoholic			Age Quit:		

4. Family Medical History

Check if any of these diseases have occurred in blood relatives. List those who have had it.

	Diabetes			Epilepsy			Anxiety	
	High Blood Pressure			Arthritis			Depression	
	Anemia			Allergy			Cancer (type?)	
	Bleeding Disorder			Asthma				
	Thyroid Disease			Stroke			Heart Trouble	
	Tuberculosis			Suicide			Other (list)	

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NEW PATIENT INFORMATION (ADULT) Cont.

Please list any close relatives who have died and the cause of death:

Relative:	Cause of Death:	Age at Death:

5. Personal History

List those who are living at home with you (spouse, children, parent, ect):

_____

Your Last grade of education? _____ Occupation? _____

Spouse's Occupation? _____

Hobbies? _____

How long have you lived in Idaho? _____

6. Woman's History

Age began menstrual periods: _____ Number of pregnancies? _____ Miscarriages? _____

Abortions? _____ Age at Menopause: _____ When was last Mammogram: _____

Describe your menstrual cycle: _____

Any history of an abnormal Pap? _____

7. Medical Providers:

Please list all medical providers you have seen in the last 5 years and why you see them:

Name:	Contact:	Reason:

8. Oral History:

Describe your overall oral health: _____ Dentures? _____ Bridges/implants? _____

Who is your dental provider? _____ Date of last visit: _____

9. Mental Health History:

Do you see a mental health professional? _____ If yes, Who? _____

Why? _____

10. Vision History:

Do you see an eye doctor? _____ If yes, Who? _____

Date of last visit: _____

11. Do you have an advanced directive such as a DNR directive or Living Will? [ ] Yes [ ] No

If no, would you like information about advanced directives? [ ] Yes [ ] No

12. Is there anything else you would like your doctor to know?

_____

_____

_____

_____