

New Patient Information (Adult)

eferred name:						/	/	Date:	//_
List the medicin	nes you a	are currer	ıtly takir	ıg:					
Medication/dose/times per day			Medication/dose/times per day			Medication/dose/times per day			
_									
Preferred Phar	macv:								
	<i>.</i> —								
List any allergic	es you ha	ave and d	escribe r	reaction:					
Check if you ha	eve or ha	ve had an	ov of the	following	illnesse	g•			
	Check if you have or have had a Rheumatic Fever Pneum		<u> </u>		Cancer		Tuberculosis		
Heart Trouble			Emphysema		Menstrual Problems		ems	Glaucoma	
High Blood Pressure		Ulcers			Stroke		Colitis		
Asthma	1 		Hepatitis		Epilepsy / Convulsions		Blood Clots		
Hay Fever			Urinary Tract Problems		Anxiety / Depression		Sexual Problems		
Diabetes	,		Venereal Disease		Skin Problems		Thyroid Problems		
Anemia	Anemia Ar		thritis		H.I.V.				
Other (specify)									
Surgery, Injury				Year	F	Iospital		Docto	r's Name
hospita	<u>alization</u>			or Age					
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NEW PATIENT INFORMATION (ADULT) Cont. Please list any close relatives who have died and the cause of death: Age at Death: Relative: Cause of 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?