NEW PATIENT HISTORY FORM

NAME _____ **DATE OF BIRTH** _____

Preferred Language _____

Reason for Visit

_____

_____

_____

Current Medications

Please list ALL medications you are currently taking, including non-prescription drugs or supplements.

Medication/Product Name **Strength and Frequency**

_____

_____

_____

_____

_____

PREFERRED PHARMACY *(Please list your preferred pharmacies for prescriptions.)*

	Pharmacy Name	Pharmacy Address
First Choice		
Second Choice		
Third Choice		

Past Medical History *(Do you have any of the following (Please check all that apply))*

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Thyroid Disease _____
☐ Liver Disease _____
☐ Cancer (type) _____
☐ Eye Disease _____
☐ Heart problems
☐ Angina
☐ Anemia
☐ Asthma
☐ Stroke
☐ Tuberculosis
☐ HIV/AIDS
☐ Stomach or peptic ulcer
☐ Kidney disease
☐ Tuberculosis
☐ Epilepsy (seizures)

Other medical conditions or any surgeries (operations) (please list):

_____

_____

Social History *(Please answer all questions. Put N/A if necessary)*

- What is the highest level of education you have completed? (Check one)
  Grades: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐Associates ☐Bachelor's ☐Masters ☐Doctorate ☐Technical School
- How many people live with the patient? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Other_____
- Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
- Have you ever used any illicit or recreational drugs? ☐ Yes ☐ No. If yes, please specify? _____
- How often do you drink alcohol?
  ☐ Once/twice a year ☐ Once a month ☐ Once a week ☐ Several times a week ☐ Daily ☐ Never
- Have you ever been involved in an alcohol or drug treatment program? ☐ Yes ☐ No
- Did your parents or any family member have a problem with alcohol when you were a child? ☐ Yes ☐ No
- Do you smoke cigarettes? ☐ Yes ☐ No. If yes, how many? _____
- Have you ever smoked cigarettes in the past? ☐ Yes ☐ No. When did you quit? _____
- In the past year have you been hit, kicked, or physically hurt by another person? ☐ Yes ☐ No
- Are you in a relationship with someone who threatens or physically harms you? ☐ Yes ☐ No
- Have you ever been abused? ☐ Yes ☐ No
- Do you eat a balanced diet? ☐ Yes ☐ No
- Do you exercise regularly? ☐ Yes ☐ No

Family History

(Please describe all family health problems (condition, age of onset, reason for death).)

Mother

Father

Sibling(s)

Other

Allergies

Allergen	Severity *(Mild, Moderate or Severe)*	What was the reaction

General Review of Symptoms (Check ALL that apply)

General
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Decreased exercise tolerance
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Weakness

Eyes
- ☐ Blurry vision or vision loss
- ☐ Eye pain
- ☐ Redness or dryness

Ear, nose, throat
- ☐ Hearing loss
- ☐ Difficulty swallowing
- ☐ Ear pain
- ☐ Ear discharge

Skin
- ☐ Hair loss
- ☐ Rash

Heart and Lungs
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest pain or tightness
- ☐ Palpitations
- ☐ Swollen legs or feet
- ☐ Difficulty lying flat
- ☐ Sleep apnea

Psychiatric
- ☐ Anxiety
- ☐ Stress
- ☐ Depression
- ☐ Memory loss
- ☐ Restlessness

Muscle/Joints
- ☐ Joint pain or swelling
- ☐ Muscle pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn/indigestion
- ☐ Change in bowel habits
- ☐ Blood in stools

Neurologic
- ☐ Confusion
- ☐ Headaches
- ☐ Dizziness
- ☐ Numbness or tingling
- ☐ Tremors

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive Sweating
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Incontinence

Hematologic
- ☐ Easy Bleeding
- ☐ Easy Bruising

Patient Health Questionnaire – 9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle your answer)*	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down, depressed or hopeless	0☐	1☐	2☐	3☐
3. Trouble falling or staying asleep, or sleeping too much	0☐	1☐	2☐	3☐
4. Feeling tired or having little energy	0☐	1☐	2☐	3☐
5. Poor appetite or overeating	0☐	1☐	2☐	3☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0☐	1☐	2☐	3☐
7. Trouble concentrating on things such as reading the newspaper, or watching television	0☐	1☐	2☐	3☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0☐	1☐	2☐	3☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0☐	1☐	2☐	3☐
Total Score				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely Difficult ☐