New Patient and Family History

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

Patient Information

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

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

E-mail: _____

How did you hear about us? _____

Previous Physician: _____
Name Address City State Zip Code

Occupation: _____

Number of Children: _____ Ages: _____

Reason for being seen today: _____

List any allergies and types of reactions: _____

List any current medications: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Lifestyle Information

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? _____
(Cigarettes, Cigars, Snuff)

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

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

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

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

Male: Last colonoscopy: _____ Last PSA screening: _____
Last prostate exam: _____ Last pneumonia vaccine: _____
Testicles: Have you ever been trained properly for testicular self-exam? ☐ Yes ☐ No

Please return completed form to the appropriate physician's office.

River Hills
FAMILY MEDICINE

New Patient and Family History, cont'd.

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

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

Medical History

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

Problem / Condition			Date Occurred	Problem / Condition			Date Occurred
Alcoholism	☐Yes	☐No		High blood pressure	☐Yes	☐No	
Arthritis	☐Yes	☐No		High cholesterol	☐Yes	☐No	
Asthma/COPD	☐Yes	☐No		Kidney disease	☐Yes	☐No	
Cancer	☐Yes	☐No		Osteoporosis	☐Yes	☐No	
Depression/anxiety	☐Yes	☐No		Seizures	☐Yes	☐No	
Diabetes	☐Yes	☐No		Stroke	☐Yes	☐No	
Glaucoma	☐Yes	☐No		Thyroid disease	☐Yes	☐No	
Heart disease	☐Yes	☐No		Tuberculosis	☐Yes	☐No	
Other:				Other:			

Surgery / Injury / Hospitalization	Date Occurred	Surgery / Injury / Hospitalization	Date Occurred

Family History

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

(M) = Maternal (P) = Paternal

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	☐Living ☐Deceased		Grandmother (P)	☐Living ☐Deceased	
Father	☐Living ☐Deceased		Grandfather (P)	☐Living ☐Deceased	
Children	☐Living ☐Deceased		Aunt(s)	☐Living ☐Deceased	
Brother(s)	☐Living ☐Deceased		Uncle(s)	☐Living ☐Deceased	
Sister(s)	☐Living ☐Deceased		Cousin(s)	☐Living ☐Deceased	
Grandmother (M)	☐Living ☐Deceased		Other:		
Grandfather (M)	☐Living ☐Deceased		Other:		

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New Patient and Family History, cont'd.

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

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

Immunization	Date of your last	Immunization	Date of your last
Tetanus and/or Pertussis Shot		Flu Shot	
Pneumonia Shot		Gardasil/Cervical Cancer Shot	
Shingles Shot		Other:	

Current or Present Problems
(If additional space is needed then please copy this page)

Problem / Condition	How long	Problem / Condition	How long
Bleeding from bowels ☐Yes ☐No		Joint pain ☐Yes ☐No	
Breathing ☐Yes ☐No		Menstrual periods ☐Yes ☐No	
Mood ☐Yes ☐No		Rash/itching ☐Yes ☐No	
Digestion ☐Yes ☐No		Menstrual periods ☐Yes ☐No	
Dizziness/fainting ☐Yes ☐No		Sex organs ☐Yes ☐No	
Frequent headaches ☐Yes ☐No		Urination ☐Yes ☐No	
Hearing ☐Yes ☐No		Vision ☐Yes ☐No	
Other:		Other:	

Patient Signature:_____ Date:_____

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

Provider Signature:_____ Date Reviewed:_____

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