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| NEW PATIENT HISTORY FORM |
| Name (Last, First, M.I.): |  | 🞎 M 🞎 F | DOB: |  |
| Cell phone #: |  | Other Phone #: |  |
| **Primary care doctor:** |  | Referring doctor: |  |
| **Gynecologist, if applicable:** |  | Endocrinologist, if applicable: |  |
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| PERSONAL HEALTH HISTORY |

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| List any medical problems that other doctors have diagnosed: |
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| Surgeries (use back page if needed): |
| Year | Type of Surgery | Reason for Surgery |
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| List your prescribed drugs and over-the-counter drugs, including vitamins and supplements (use back page if needed): |
| Name the Drug | Strength | Frequency Taken |
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| Allergies to medications |
| Name the Drug | Reaction You Had |
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| HEALTH HABITS AND PERSONAL SAFETY |
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| Exercise | 🞎 Sedentary (No exercise) |
| 🞎 Mild exercise (i.e., climb stairs, walk 3 blocks, golf) |
| 🞎 Vigorous exercise (i.e., work or recreation, about 4x/week for 30 min.) |
| Caffeine | 🞎 None | 🞎 Coffee | 🞎 Tea | 🞎 Cola |
| # of cups/cans per day? |
| Alcohol | Do you drink alcohol? | 🞎 | Yes | 🞎 | No |
| How many drinks per week? |
| Tobacco | Do you use tobacco? | 🞎 | Yes | 🞎 | No |
| 🞎 Cigarettes – pks./day | 🞎 Chew - #/day | 🞎 Pipe - #/day | 🞎 Cigars - #/day |
| 🞎 # of years | 🞎 Or year quit |
| Drugs | Do you currently use recreational or street drugs? | 🞎 | Yes | 🞎 | No |
| Have you ever given yourself street drugs with a needle? | 🞎 | Yes | 🞎 | No |

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| FAMILY cancer HISTORY |
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|  | Age | Cancer diagnosis? If so, List Type |  | Age | Cancer Diagnosis? If Yes, List Type |
| Father |  |  | Grandmother*Maternal* |  |  |  |
| Mother |  |  | Grandfather*Maternal* |  |  |  |
| **Siblings** | 🞎 M🞎 F |  |  | Grandmother*Paternal* |  |  |  |
| 🞎 M🞎 F |  |  | GrandfatherPaternal |  |  |
| 🞎 M🞎 F |  |  | **Aunts**Maternal |  |  |
| 🞎 M🞎 F |  |  | **Aunts**Paternal |  |  |
| 🞎 M🞎 F |  |  | **Uncles***Maternal* |  |  |
| Children | 🞎 M🞎 F |  |  | **Uncles***Paternal* |  |  |  |
| 🞎 M🞎 F |  |  | Cousins*Maternal* | 🞎 M🞎 F |  |  |
| 🞎 M🞎 F |  |  |  | 🞎 M🞎 F |  |
| 🞎 M🞎 F |  |  | **Cousins**Paternal | 🞎 M🞎 F |  |
| 🞎 M🞎 F |  |  |  | 🞎 M🞎 F |  |

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| Breast Patients ONLY |
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| Age at onset of menstruation:  | Age at onset of menopause: |
| Have you ever had a breast biopsy? |
| Have you ever taken hormone replacement therapy?  | If so, for how many years? |
| When was your last mammogram? | 🞎 | Yes | 🞎 | No |
| Number of pregnancies: | Age first child delivered: | Number of live pregnancies: |
| Are you pregnant or breastfeeding? | 🞎 | Yes | 🞎 | No |
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| OTHER PROBLEMS |
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| Check if you are CURRENTLY having trouble with any of the following: |

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|  | **General**:\_\_ Fever \_\_ Chills \_\_ Sweats\_\_ Frequent headaches\_\_ Decreased appetite\_\_ Fatigue\_\_ Feeling poorly\_\_ Weight loss\_\_ Weight gain |  | **Heart/Vascular**:\_\_ Chest Pains\_\_ Palpitations\_\_ Fainting\_\_ Painful breathing with exercise\_\_ Lightheaded when standing up\_\_ Calf pain\_\_ Swelling of arms/legs |  | **Genitourinary**:\_\_ Vaginal discharge\_\_ Incontinence\_\_ Painful urination\_\_ Blood in urine\_\_ Urinary frequency\_\_ Kidney stones\_\_ Abnormal vaginal bleeding\_\_ Excessive urination at night |
|  | **Eyes**:\_\_ Blurring\_\_ Double vision\_\_ Vision loss\_\_ Eye pain |  | **Respiratory**:\_\_ Cough\_\_ Painful breathing\_\_ Excessive sputum\_\_ Spitting up blood\_\_ Wheezing\_\_ Snoring |  | **Musculoskeletal**:\_\_ Back pain\_\_ Joint pain\_\_ Muscle cramps\_\_ Muscle weakness\_\_ Stiffness\_\_ Arthritis |
|  | **Ears/Nose/Throat**:\_\_ Ringing of the ears\_\_ Decreased hearing\_\_ Nasal congestion\_\_ Sore throat\_\_ Hoarseness\_\_ Difficulty swallowing |  | **Gastrointestinal**:\_\_ Nausea \_\_ Vomiting\_\_ Diarrhea (6 or more loose stools daily)\_\_ Constipation\_\_ Change in bowel habits\_\_ Abdominal pain\_\_ Black or bloody stools\_\_ Yellow skin |  | **Skin**:\_\_ Rash\_\_ Itching\_\_ Dryness\_\_ Suspicious moles |
|  | **Endocrine**:\_\_ Cold intolerance\_\_ Heat intolerance\_\_ Excessive thirst\_\_ Excessive hunger\_\_ Frequent urination |  | **Heme/Lymphatic**:\_\_ Abnormal bruising\_\_ Bleeding\_\_ Enlarged lymph nodes  |  | **Allergic/Immunologic**:\_\_ Itching\_\_ Hay fever\_\_ Persistent/frequent infections |
|  | **Psychiatric**:\_\_ Depression\_\_ Anxiety\_\_ Suicidal ideation\_\_ Sleep disturbance |  | **Neurological:**\_\_ Confusion\_\_ Memory loss |  | **Other:** |