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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 | | | | | | | | | |
|  | | | | | | | | | |
| 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 |  |  | Grandfather Paternal |  | |  |
| 🞎 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:** |