Cherry Bend Family Care, PLC
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# WELCOME TO OUR PRACTICE

As a new patient, please complete the information below to the best of your ability.

Patient Name _____ Date_____/_____/_____

Reason for your visit today _____

**PAST HISTORY:** Please check (✓) if you've had the following:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeds easily
- ☐ Blood transfusion
- ☐ Cancer, tumor
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Depression
- ☐ Eczema, hives, rashes
- ☐ Epilepsy, seizures
- ☐ Eye problems
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ HIV
- ☐ Kidney/bladder problems
- ☐ Liver disease, hepatitis, yellow jaundice
- ☐ Lung disease, TB
- ☐ Mumps, measles, chicken pox
- ☐ Nervous breakdown, mental illness
- ☐ Osteoporosis
- ☐ Phlebitis/blood clots
- ☐ Rheumatic fever
- ☐ Rubella, German measles
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid disease
- ☐ Ulcer in stomach/duodenum

Other illnesses_____

**PAST SURGERIES/HOSPITALIZATIONS**

1._____ Year_____ 5. _____ Year_____
2._____ Year_____ 6. _____ Year_____
3._____ Year_____ 7. _____ Year_____
4._____ Year_____ 8. _____ Year_____

**SOCIAL HISTORY**

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Spouse's Name_____ # of Children_____

Occupation _____

Do/Did you smoke? ☐ Yes ☐ No Number of packs/day_____ ☐ Cigar ☐ Pipe How long_____ Date Quit _____

Do you consume alcohol? ☐ Yes ☐ No Number of drinks/day_____ Last drink _____

Do you drink caffeine?_____ ☐ Yes ☐ No Number of cups/day_____

Do you use recreational drugs? ☐ Yes ☐ No If yes, list_____

Do you live alone? ☐ Yes ☐ No Who is your support person _____

Do you function independently at home? ☐ Yes ☐ No Comment_____

Do you have needs related to your spiritual/cultural/language background? ☐ Yes ☐ No _____

Are you afraid of anyone in your home or anyone close to you? ☐ Yes ☐ No

Do you wear seat belts? ☐ Yes ☐ No

Do you have a living will or durable power of attorney? ☐ Yes ☐ No

**DRUG, MEDICATIONS, VITAMIN OR HERBAL SUPPLEMENTS:** ☐ Taking No Medications

Please list names of medications, dosage, and how many times you take a day (If names not known print what they are for and bring them with you.)

1._____ 6. _____
2._____ 7. _____
3._____ 8. _____
4._____ 9. _____
5._____ 10. _____

**ALLERGIES TO MEDICATIONS:** ☐ No Known Allergies

What happens when you take medications?

1. _____
2. _____
3. _____
4. _____

| FAMILY HISTORY: | If Living | If Not Living | | Check If Any Member Has Or Had | | | | Other |
|---|---|---|---|---|---|---|---|---|
| | Age | Age | Cause of Death | Diabetes | Heart Trouble (heart attack at what age) | High Blood Pressure | Cancer (what kind?) | |
| Father | | | | | | | | |
| Mother | | | | | | | | |
| Brothers/Sisters 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| Children 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| Grandparents 1. | | | | | | | | |
| 2. | | | | | | | | |