NEW PATIENT FORM **ADULT FEMALE** **DATE**________________

NAME ____________________________ DATE OF BIRTH ____________

Current Medications and Dosage (include supplements, vitamins and over-the-counter medications you take everyday) PLEASE BRING YOUR MEDICATION LIST OR BOTTLES WITH YOU:

____
____
____

Allergies to Medications and type of reaction:

____

Have you ever been diagnosed with: Please give year of diagnosis

Heart Problems: High Blood Pressure _____ High Cholesterol ____ Heart Irregularity ____
Heart Attack _____ Congestive Heart Failure ____ Coronary Artery Disease ____
Other ___________
Lung Problems: Asthma ____ Emphysema (COPD) ____ Pneumonia ____ Sleep Apnea____
Chronic Cough____
Gastrointestinal Problems: Liver Problems____ Crohn's Disease ____ Colon Polyps ____
Stomach ulcers _______ Colitis ____ Reflux/Heartburn____
Kidney Problems: Kidney Stones _____ Kidney Failure _____
Genitourinary Problems: Overactive Bladder_____ Frequent Bladder Infections______
Musculoskeletal Problems: Gout ____ Fibromyalgia ____ Chronic Pain____ Arthritis ____
Lupus____ Osteoporosis_____
Any broken bones (which bone and the year of injury) ____
Endocrine Problems: Diabetes ____ Thyroid Problems _____
Neurological Problems: Multiple Sclerosis ____ Parkinson's ____ Migraine Headaches ____
Seizure Disorder ____ Strokes____
Blood Disorders: Anemia ____ Leukemia ____ Blood disorders ____ Blood Clots (Legs or Lungs) ____
Allergies: Seasonal/Hay fever_____ Eczema _____
Psoriasis ____ Frequent Sinus Infections _____
Cancer: Bone _______ Brain __________ Colon _____
Lung _______ Skin ___________ Other Cancers____
Breast_______

Have you ever been diagnosed with:

Depression ________ Mood Disorder _________ Bipolar Disorder ______
Eating Disorder _____ Anxiety________
Other: Cataracts ____ Glaucoma _______
AIDS ________ HIV _______

Female History:

#pregnancies____ #deliveries____ Abortions____ Miscarriages____
Any problems with pregnancies?_____________________________
Date of Last Menstrual Period________ Do you have irregular cycles?____
Date of Last Pap exam ________ Any abnormal Paps?____
Last Mammogram? ________ Any abnormal Mammograms? ____
The Date of Your Last Physical Exam: _______________

List any Specialists you are currently seeing:

____
____

Have you had any surgeries? List Date of Surgery and Location

Appendix ____________ Joint Scope ___________ Biopsy __________________
Gallbladder ________ Hernia Repair __________
Joint Replacement __________ Sinus surgery __________________
Cataract ___________ Heart Valve Replacement ____________________
Pacemaker Implant _________ Tonsils/Adenoids ______________
Open Heart_______ Hysterectomy_____________ D&C____________________
C-section_________________ Tubal Ligation______________________

Other Surgeries:
____
____

FAMILY HISTORY: (Includes parents, immediate grandparents, immediate aunts/uncles, and siblings) Please state who and their age. Has anyone been diagnosed with:

High Blood Pressure _____________ High Cholesterol _______________
Heart Attack_____________ Heart Failure _____________ Diabetes ("sugar") _________________
Low or High Thyroid ____Asthma __________________ COPD/Emphysema ___________________
Crohn's Disease __________ Colon Polyps __________________ Reflux Disease __________
Irritable Bowel Syndrome __________ Hepatitis/Liver problems _______________
Kidney failure __________ Kidney Stones _________________ Fibromyalgia ___________
Osteoarthritis _____________ Osteoporosis __________________ Rheumatoid Arthritis ___________
Seizures ________________ Migraines ______________ Multiple Sclerosis _______ Stroke__________
Lupus_____________ Anemia __________ Alcoholism __________________Depression ____________
Anxiety _________________ Bipolar Disorder ________________ Cancer ________________
Other: ____

<u>SOCIAL HISTORY:</u>

Occupation:
____Married/Single/Widowed/Divorced
Number of children: ________ Ages: _____ _____ _____ _____ _____ _____ _____
Hobbies: ____
Exercise: Type of Exercise __________________ Frequency ______________________________
Tobacco Use:
Cigarettes: ___ packs per day for ____ yrs. Cigars: _____ cigars per week for ____ yrs.

Alcohol Intake: Current Alcoholic: ____ Past Alcoholic: ____
Current Use: Rare_______ Social ______ Regular ______
Alcohol: Beer _____Wine _____Liquor # of Drinks: ____ per day ____ per week

<u>Have you ever used illicit or street drugs? Yes / no</u>

Current Use ____________ Prior Use ______

<u>Have you ever had:</u>

Chlamydia _____ Gonorrhea ______ Herpes _____________
Human Papillomavirus (HPV) ____ Syphilis ____ Other ______________
Measles ______ Mumps _______ Hepatitis A, B, or C ________
Malaria ______ Rocky Mountain Spotted Fever _______
Severe Strep or staph infection __________ Diphtheria ___________
Rabies _______ Tetanus _______ Asbestosis ___________
Other reportable diseases: ____

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT