NEW ADULT PATIENT FORM

Birth Sex: Male / Female

Date: _____

Name: _____ **DOB:** _____

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

_____
_____
_____

Allergies to Medication 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 _____ Breast_____Other Cancers____

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: _____

SOCIAL HISTORY:

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
Have you ever used illicit or street drugs? Yes / no
Current Use _____ Prior Use _____

Have you ever had:

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