Integritas Wellness Institute – NEW PATIENT HISTORY

Name:_____ **Birth Date:** _____ **Marital Status:** _____

Race: American Indian/Alaskan Native Asian African American/Black

Native Hawaiian/Pacific Islander Caucasian Other_____

Ethnicity: Hispanic/Latino Other_____

Do you have or have had any of the following conditions:

o Asthma/COPD/Emphysema o Cancer (type)_____

o Depression/Anxiety o Diabetes o Gastroesophageal Reflux (GERD) o High Cholesterol

o Hypertension o Kidney Disease o Obesity/Overweight o Osteoporosis o Stroke

Heart History: o CAD o CHF o Heart Attack o Murmur o Stents

Other Medical Conditions _____

_____ _____

_____

Surgical History and Dates (approximate) _____

_____

_____

Family History:

Mother: Father:

Siblings:

Other family members:

Social History Occupation: _____

Do you smoke? YES NO If yes, how much? _____ How long? _____

If no, have you ever smoked? YES NO How long? _____ When did you quit? _____

Do you live with a smoker? YES NO

Do you drink alcohol? YES NO How many drinks per day? ____ How many drinks per week? ____

Do you drink caffeine? YES NO How much per day? _____

What do you do for exercise? _____ Do you use any illegal drugs? YES NO

Latex Allergy? YES NO

Medication Allergies _____

_____

Medications _____Please use other Medications List Form_____

Pharmacy Information:

Name:_____ Pharmacy Number_____

OB/GYN- Women Only

First day of last menstrual cycle_____ Number of pregnancies_____ Number of deliveries_____
Number of miscarriages_____ Birth control method_____

Date of hysterectomy _____Total/Partial

Health Screening History

Colonoscopy Date: _____ Doctor:_____

Mammogram Date: _____ Location:_____

Pap smear Date: _____ Doctor:_____

Bone Density Date: _____ Doctor:_____

Eye Exam Date: _____ Doctor:_____

Patient Signature_____ **Date:**

Please list the NAME of any specialist listed below that you see

Asthma/Pulmonary_____ Cardiology_____

Endocrinology_____ Gastroenterology_____

OB/GYN_____ Ophthalmology_____

Dermatology_____ Other_____