BRADFORD FAMILY MEDICINE, INC.
ADULT NEW PATIENT HISTORY

Patient Name:_____ **Date of Birth:**_____**Today's Date:**_____
(Last) (First) (MI)

Medication Allergies: (Please list all medication allergies and the reaction that occurred)

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

Medical Problems: (Please list all past medical problems and hospitalizations)

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

Previous Surgeries:

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

Medications: (Please include medication name/dose/frequency as well as any over-the-counter and herbal meds)

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

OB/GYN Information: (Females only)

Age when you began your periods:_____How long do they last?_____
Are they regular?_____# Days:_____Heavy/Moderate or Light Flow?_____
Age when you stopped having periods (if applicable):_____
List number of pregnancies:_____List number of full term deliveries:_____Preterm deliveries:_____
List number of ectopics:_____Miscarriages:_____Terminations:_____Living children:_____
Have you ever had an abnormal pap smear? (list details):_____
Number of lifetime partners?_____Prior sexually transmitted diseases?_____
List type(s) of birth control (including current):_____Do you use hormone therapy?_____

Routine Health Screening: (Please list dates if applicable)

Last Tetanus Shot:_____ Last Pap:_____
Last Flu Shot:_____ Last Mammogram:_____
Last Pneumonia Shot:_____ Last PSA (Prostate):_____
Last Covid Shot:_____ Last Colonoscopy:_____
Last Shingles Shot:_____ Last Cholesterol:_____

Advanced Directives: (Living will, healthcare power of attorney, DNR, POLST form, etc.)

Do you have advanced directives?:_____ Please provide our office with copies and discuss at your visit.

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Patient Name:_____ **Date of Birth:**_____**Today's Date:**_____
(Last) (First) (MI)

Family History:

Relative	Alive	Current Age/ Age of Death	Health Issues/Cause of Death (include all known issues including cancer types/stroke/heart issues /diabetes/etc.)
Father			
Mother			
Siblings			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Other			

Social History:

Tobacco/Nicotine:
Do you smoke/chew?_____Vape?_____Amount:_____Year you began/quit:_____
Alcohol/Drugs:
Do you drink alcohol?_____Type/Amount/Frequncy:_____
Do you use marijuana?_____Amount/Frequency:_____
Have you used other drugs?_____Type(s)/Amount/Frequency:_____
Diet/Exercise:
Do you follow a special diet?_____Type:_____
Do you exercise regularly?_____Type/Frequency:_____
Household Information/Injury Prevention:
Marital Status:_____Household Members:_____
Do you feel safe in your home/current relationship?_____
Do you have smoke alarms installed?_____Carbon monoxide detectors:_____Do you wear seatbelts?_____
Occupation: (List current occupation and any previous occupational exposures)
_____
_____