



	NEW PATIENT	r QUESTIC	DNNAIF	RE		
Today's Date:	NAME:			Da	te o	f Birth:
What are your health goals fo	r the next year?					
What are your top two health  1	•		-			
Previous Primary Care Provid		Z				
	PERSONAL SI	JRGICAL	HISTOR	RY		
Surgical Procedure		Year	Surg	geon/Hospital		
		<u> </u>				
Diagon list All bookbooms was vi	alawa wa wa a wa a walawiwa a wa ka		- 46 - 1-	at C		
Please list ALL healthcare provi Ex. Cardiology, Pulmonologist, Nephrol Acupuncturist, Massage Therapist, Nut Counselor, Oncologist.	logist (Kidney), Urologist, Orthope	dist, Rheuma	tologist, l	Physical Therapist,	Podi: necol	atrist, Chiropractor, logist, Psychiatrist, Psychologist,
Name	Facility/Clinic 8	& City		Phone #		Specialty
AL	LERGIES - Please list all a	allergies to	medica	ations and food	S.	
Medication or Food	Reaction				Las	st Happened?
1	1					



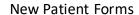


	PERSONAL	MEDIC	AL & HEALTH HISTORY		
Condition	Now	Past	Condition	Now	Past
Alcohol / Drug Addiction			Gallbladder Disease		
Allergies (Hay Fever)			GERD / reflux / heartburn		
Anemia			Glaucoma		
Anxiety			Gout		
Arthritis (Rheumatoid)			Heart Attack		
Arthritis (Osteoarthritis)			Hepatitis		
Asthma			Hypertension (blood pressure)		
AutoImmune Disease			High Cholesterol		
Bladder Problems			Irritable Bowel Syndrome		
Bleeding/Clotting Disorder			Kidney Disease/Failure		
Blood Clot (leg)			Kidney Stones		
Blood Clot (lung)			Kidney Disease - other		
Blood Transfusion			Liver Disease		
Breast Lump (benign)			Migraine Headaches		
Cancer Breast			Osteopenia/Osteoporosis		
Cancer Colon			Psoriasis		
Cancer Other Type			Pulmonary Embolism (lung clot)		
Cancer Ovarian			Prostate Problems		
Cancer Prostate			Seizures		
Cataracts			Sleep Apnea		
Colon Polyp			Stroke / TIA		
COPD (emphysema)			Thyroid Overactive (hyper)		
Coronary Artery Disease			Thyroid Underactive (hypo)		
Depression			Thyroid problems - other		
Diabetes			Ulcer		
Diverticulosis/Diverticulitis			Fractures (Broken Bones):		
Eczema (Dermatitis)			Other:		
Endometriosis			Other:		
Fibroids			Other:		



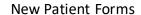


		F.A	MIL	/ ME	DICA	L HIS	TORY				
Alive  Deceased  Age currently or at death	Mother	Father	Sister (s)	Brother (s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other blood relatives (List relation)		
·											
Diseases & Conditions										Age at Diagnosis	cause of death?
Alcohol / Drug Addiction											ΥN
Alzheimer's or Dementia											ΥN
Anxiety or Depression											ΥN
AutoImmune Disease											ΥN
Asthma											ΥN
Bleeding/Clotting Disorder											ΥN
Cancer Breast											ΥN
Cancer Colon Cancer Colon											ΥN
Cancer Other Type											ΥN
Cancer Ovarian											ΥN
Cancer Prostate											ΥN
COPD (emphysema)											ΥN
Diabetes											ΥN
Genetic Disorder											ΥN
Heart Attack											ΥN
Heart Disease											ΥN
Hepatitis											ΥN
Kidney Disease											ΥN
Kidney Stones											ΥN
Liver Disease											ΥN
Stroke											ΥN
Thyroid Disease											ΥN
Other:											ΥN





Tetanus (Td) with P		er year (ii known) of vac P) Influe		
		/oderna Pfizer	J&J/Janssen	<del></del>
Pneumococcal (PPSV23)	Pr	neumococcal (PCV13)_		
Shingles: Zostavax (newer 1-dos	se)	Shinarix (older 2-dose	<i>i</i> )	
Hepatitis A He				
•			<del></del>	
Varicella (Chickenpox)				
Other				
Tool		ERSONAL TESTING HIS		
Test Angiogram	Year	Surgeon/Hospital	Results	
Biopsy				
Cardiac Stress Test				
Colonoscopy				
DEXA (bone density)				
ECG/EKG				
Echocardiogram				
EGD (stomach endoscopy)				
ERCP/MRCP				
Sleep Study				
Pulmonary Function Test				
CT				
MRI				
Other:				
Please list <b>ALL MEDICAL DEVI</b> Ex. Wheelchair, walker, cane, prosth			eded basis.	
Device	Details			Why?





## MEDICATIONS - Please complete or attach a medication list

Please list ALL PRESCRIPTION MEDICATION that you take or use regularly or on an

as needed basis.			
Medication	Dose	How many times per day?	Why?
Please list ALL <b>OVER THE COU</b> as needed basis.	INTER MEDICATION that you take	e regularly or on an	
Medication	Dose	How many times per day?	Why?

Please list ALL VITAMINS, MINERALS AND SUPPLEMENTS that you take regularly or on an as needed basis.

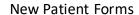
Vitamin, Mineral, Supplement	Dose	How many times per	Why?
		day?	



## **New Patient Forms**

PERSONAL/SOCIAL HISTORY
Who do you live with?
Marital Status: Single Married Divorced Widow/Widower
Spouse's Name:
How many children do you have? Do any live nearby? Y N
Do you have any pets? Y N Details:
What are your hobbies, what do you do in your spare time?
Circle the type of diet you follow: Regular Vegetarian Vegan Gluten Free Mediterranean Keto  Other:
How many fruits and vegetables do you eat daily?
How many days per week do you do moderate exercise, like gardening or going for a brisk walk?
What type of exercise do you do and how often?
How many hours of sleep do you get every night?  Do you drink alcohol? Y N  What type & how much/often? (ex.1 glass wine nightly, 6pack beer every Saturday):
Do you use tobacco? Y N
What type (smoking, vaping, chewing, snuff) and how much/often? (ex. 1/2 pack per day, tin of chew weekly):
Do you use marijuana products (CBD or THC, topical, edible, vape, smoke, pills)? Y N
What type and how much/often?
Do you ingest caffeine daily? Y N
If so, how much and of what?
Do you take opiates (vicodin, hydrocodone, tramadol, codeine, fentanyl, oxycodone, heroin)? Y N
Do you take any stimulants (Adderall, Ritalin, Methamphetamine)? Y N
Do you take any sedatives like barbiturates, benzodiazepines or hypnotics (sleep medications)? Y N
Do you use any recreational drugs? Y N

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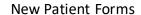
		WOMEN ONLY	1
		se, have you had any ble	
-			
	-	s and usually last	
Do you experience hea	vy bleeding or clottir	ng during your period?	N
Do you experience sev	ere cramping during	your period? Y N	
Have you had a hyster	•		
# of pregnancies:	# c	children born alive:	
# of miscarriages:		# of abortions:	
# of cesareans:			
Were there any compli	cations with any of y	our pregnancies? Y N	
Please explain:			
Are you sexually active	? Y N With men,	women or both?	
Number of sexual partr	ers in last year:		
Do you ever have sex	vithout a condom?	Y N	
Current Birth Control M	ethod:		
Are you interested in c	nanging or starting b	irth control? Y N	
Have you ever had a s	exually transmitted in	nfection? Y N	
Are you worried you m	ght currently have a	sexually transmitted infe	ction? Y N
Do you feel safe in you	r relationship? Y	N	
Does your partner ever	hit you, threaten yo	u or force you to have sex	x? <b>Y</b> N
Does your partner(s) u	se IV drugs? Y N		
Last pap:	_ Results:	Normal <b>Abnormal</b>	Don't know
Have you ever had an	abnormal pap? Y N	N	
Please explain:			
Do you have any vagir	al complaints? Y	N	
Please explain: (pain, i	ممالم مسام	harae eta ):	

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Last Mammogram:	Results: Norma	al <b>Abnormal</b>	Don't know	
Have you ever had an abnormal ma	ammogram? Y	N		
Please explain:				
Do you have any breast complaints	s? <b>Y</b> N			
Please explain: (pain, lumps, rashe	s, nipple changes	, etc):		
Last Bone Density Exam (DEXA): _				
Results: Normal O	steopenia C	Osteoperosis	Don't Know	
Do you take Vitamin D? Y N WI	hat dose & how of	ften?		_
Do you take Calcium? Y N What	at dose & how oft	en?		_
Do you take any other medicine for	r bone health/stren	ngth? Y N		
What, how much, & how often?	<u> </u>			
Have you ever broke a bone? Y	N			
Please explain:				





MEN ONLY	
Are you sexually active? Y N With men, women or both?	
Number of sexual partners in last year:	
Do you ever have sex without a condom? Y N	
Have you ever had a sexually transmitted infection? Y N	
Are you worried you might currently have a sexually transmitted infection? Y N	
Do you feel safe in your relationship? Y N	
Does your partner ever hit you, threaten you or force you to have sex? Y N	
Does your partner(s) use IV drugs? Y N	
Have you ever had problems with your prostate? Y N	
How strong is your urine stream? Strong Okay Weak Varies	
Do you ever dribble urine or are you ever incontinent? Y N	
Do you ever have pain when urinating? Y N	
Do you ever see blood in your urine? Y N	
Do you ever have trouble getting an erection? Y N	
Do you ever have any problems with ejaculation (difficulty, pain, blood)? Y N	
Have you ever had an elevated PSA (prostate specific antigen blood test)? Y N	
IF OVER 65	
Last Bone Density Exam (DEXA):	
	 on't Know
Do you take Vitamin D? Y N What dose & how often?	
Do you take Calcium? Y N What dose & how often?	
Have you ever broke a bone? Y N	
Please explain:	