Welcome to Hampstead Primary Care
New Patient Forms

Patient Name: _____ DOB: _____Date: _____

Please list **PROBLEMS** you would like evaluated today in order of significance:

1._____

2._____

3._____

Have you ever been diagnosed with? (select all that apply)

□ Asthma	□ Seasonal/ Food Allergies	□ High Blood Pressure	□ Heart Murmur
□ Cataracts	□ Glaucoma	□ Seizure/ Epilepsy	□ Lung Disease/COPD
□ Stroke	□ Heart Disease	□ Heart Attack	□ Liver Disease
□ Ulcers/ GERD	□ Digestive Disorder	□ Kidney Disease	□ Kidney Stone
□ Diabetes/Pre-Diabetes	□ Hypo/ Hyperthyroidism	□ Depression	□ Anxiety
□ Anemia	□ Bleeding Disorder	□ Bone/ Joint disease	□ Osteoporosis
□ High Cholesterol	□ Frequent Infections	□ Cancer (type)_____	□ Prostate Enlargement
□ HIV/ Hepatitis C	□ STD (type)_____	□ Mental Disorder _____	

□ Other_____

PAST MEDICAL HISTORY

Please describe and give dates of **surgeries**:

1._____

2._____

3._____

4._____

PLEASE LIST ANY SPECIALIST THAT YOU CURRENTLY SEE

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

IMMUNIZATIONS

Hepatitis B □ Yes □ No Date: _____ Hepatitis A □ Yes □ No Date: _____

Tetanus shot □ Yes □ No Date: _____Influenza (flu) □ Yes □ No Date: _____

Pneumonia Shot □ Yes □ No Date: _____Shingles Shot? □ Yes □ No Date: _____
Shingles Outbreak? □ Yes □ No Date: _____

Have you ever had a test for Tuberculosis? if yes (select): □ Positive □ Negative Date: _____

How was your Positive Tuberculosis diagnosed: Skin Prick/Blood Test/Chest X-ray?

Have you ever had a blood transfusion? if yes: Date(s): _____

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FAMILY HISTORY	Living/Deceased	Cause & Age of Death	Medical Conditions
MOTHER			
FATHER			
SISTER (S)			
BROTHER (S)			
DAUGHTER (S)			
SON (S)			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			

FAMILY HISTORY CONTINUED:

Is there any family history of?	Type or Age of onset	Relation to you
Cancer		
Heart Attack		
Stroke		
Mental Illness		

SOCIAL HISTORY

Marital Status: _____Your Occupation: _____

# of Children: _____ # Boys_____ # Girls_____# of People in Household: _____
Currently Live With: _____

Gender Identity □Male □Female □Female to Male □Male to Female

Sexual Orientation: □Lesbian/Gay □Straight □Bi-sexual □Don't know

Sexual Activity: □ Monogamous Relationship □ Not sexually active □ Multiple partners □ Does not practice "safe" sex

Are you an **ORGAN DONOR?** _____

List the amount **PER DAY** of beverages you regularly consume:

Coffee/Tea: _____ Beer: _____ Wine: _____ Hard liquor: _____ Soda: _____ Water: _____

I drink alcohol: □ Currently □ Occasionally □ Never □ Socially

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SOCIAL HISTORY CONTINUED

Smoking Status: □Never a smoker □ Current Smoker- How many packs per day: _____ Start Date: _____

□ Former Smoker - Smoking amount: _____ Start date: _____ Quit Date: _____ Any Smokers in home? □ Yes □ No

Have you ever used illicit drugs: □Yes □No If so, last date and which drug(s)?

_____

OTHER

Recent **Significant Changes** in Your Life? □Yes □No If yes, Explain_____

Financial Hardships? □Yes □No Have Special Stresses in Your Life? □Yes □No

I am **NOT** happy with (select those that apply) □Myself □My Health □My Work □My Partner □My Life

Do you feel safe in your current relationships? (family, friends, significant other) _____

Do you have a Living Will or Advanced Directive? _____

Do you exercise regularly? □Yes □No Type of exercise and frequency: _____

_____

Are you happy with your weight? □Yes □No How many meals/snacks do you eat per day? _____

How many meals do you eat out/carry out per week? _____

List any nutrition or diet concerns you would like help with: _____

If you are on a special diet? If yes, please explain:

_____

_____

Do you have regular Dental check-ups? □Yes □No How often do you brush/floss per day? _____

When was your last Eye exam? _____

Do you wear your seatbelt? □ Always □ Sometimes □ Never

Do you ride a motorcycle? □ Y □ N Bicycle? □ Y □ N Ski/Snowboard? □ Y □ N Skateboard? □ Y □ N

If yes, do you wear a helmet? □ Y □ N

Have you fallen in the last 6 months? If so, explain: _____

Have you been exposed to any Toxic Substances, such as asbestos, DES, radiation, chemicals? □ Yes □ No

If yes, please explain: _____

Do you have a smoke detector in the home: □ Y □ N When was it last checked? _____

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History Form

REVIEW OF SYSTEMS:
Select those items you **currently** have significant problems with.

GENERAL

□Recent Weight Change	□Increased Thirst or Urination	□Night Sweats/Hot Flashes
□Always Hot/Always Cold	□Rashes or Skin Problems	□Significant Fatigue

Do you have chronic pain problems? □Yes □No

BREASTS: Men & Women

□Lumps/Tenderness	Do You Do Monthly Self Breast Exams? □Y □N
□Drainage from nipples	Month and Year of Last Mammogram: _____

EYE, EAR, NOSE, AND THROAT

□Glaucoma	□Blurred or Double Vision- Ever	□Use Glasses or Contact Lenses
□Hearing Loss	□Brief Loss of Vision- Ever	□Use Dentures (Partial or Total)
□History of Radiation Therapy to Head or Neck		□Teeth or Gum Problems

CARDIOPULMONARY

□Shortness of Breath with Activity	□Dizziness	□Chest Pain
□Daily Sputum (Phlegm) Production	□Coughing Up Blood	□Heart Palpitations
□Difficulty Breathing While Lying Flat	□Leg Cramps While Walking	□Wheezing
□Waking Up Short of Breath	□Daily Cough	□Ankle Swelling

GASTROINTESTINAL

□Change of Appetite	□Abdominal Pain	□Blood in Stool/Black Stool
□Difficulty Swallowing	□Diarrhea/Constipation	□Frequent Nausea/Vomiting
□Heartburn	□Indigestion from Fatty Foods	

NEUROPSYCHIATRIC

□Frequent Disabling Headaches	□Difficulty Sleeping	□Tremors
□Frequent Anxiety or Anxiety Attacks	□Memory Loss	□Passing Out/Fainting
Treated in Past for Emotional or Psychological Problems: please describe _____		□Often Feel Sad or Depressed

MUSCULOSKELETAL & SKIN

□Frequent Neck or Back Pain	□Muscle Pain	□Disabling Night Leg Cramps
□Joint Problems	□Use a Brace or a Splint	

Mole that has changed color, size, shape, or won't heal? □Yes □No

GENITOURINARY: MEN & WOMEN

□Urinary Tract Infections	□Sores in the Genital Area
□Difficult or Painful Urination	□Blood in Urine
□History of Kidney or Bladder Stones	□Urination More Than Once a Night
□History of Four or More Sex Partners	□Sexual Intercourse Before 18 years old
Method of Birth Control: _____	

Have you ever had any Sexually Transmitted Disease: □Yes □ No
if yes, please describe: _____

GENITOURINARY: MEN ONLY

Pain or Lump in Testicles/Scrotum □Yes □No	Do you do Self Testicular Exam: □Yes □No Have you had a PSA: □Yes □No

GENITOURINARY: WOMEN ONLY

Age of first Period: _____	Frequency/Length of Menstrual Periods: _____
Date of Last Menstrual Period: _____	Change in Menstrual Pattern □Y □N
Number of Pregnancies: _____	Number of Children: _____
Disabling Menstrual Cramps □Y □N	Unusual Vaginal Discharge/Itching □Y □N
Date of Last Pap Smear: _____	Date of last Mammogram_____
History of Abnormal Pap Smear: □Y □N	Any Treatments for Abnormal Pap: _____

Provider Comments

Patient Name: _____ DOB: _____Date: _____

Medication List

Preferred Pharmacy: _____Phone: _____
Pharmacy Address: _____

MEDICATION ALLERGIES: (such as penicillin) _____
What happens when you take that medication? _____

OTHER ALLERGIES: (such as bees, foods, latex, etc.) _____
What happens when you are exposed? _____

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		