NEW PATIENT VISIT – HEALTH HISTORY

Name _____ Age _____ Date of Birth _____Today's Date _____

TELEPHONE: HOME:_____ MOBILE: _____ WORK: _____

EMAIL ADDRESS: _____
(To receive health and practice information)

PAST MEDICAL HISTORY	NO / YES	IF YES PLEASE LIST:
Have you had any serious illnesses?	N Y	_____
Have you been hospitalized?	N Y	_____
Have you had any surgeries?	N Y	_____

HAVE YOU EVER HAD:	NO / YES		
Cancer	N Y	High Cholesterol	N Y
Pneumonia	N Y	Diabetes	N Y
Tuberculosis	N Y	Hepatitis	N Y
Chicken Pox	N Y	Heart Disease	N Y
High Blood Pressure	N Y	Stroke	N Y
Sexually transmitted diseases	N Y	Blood Clots	N Y
Does a partner, or anyone at home, hurt, hit, or Threaten you?	N Y		

MEDICATION: (INCLUDE HERBS AND VITAMINS) HOW OFTEN TAKEN:

_____

_____

_____

ALLERGIES
Do you have any allergies? NO / YES If yes to what? _____

FAMILY HISTORY: (IF LIVING) (IF DECEASED)

AGE-HEALTH STATUS AGE AT DEATH – CAUSE OF DEATH

FATHER: _____

MOTHER: _____

SIBLING's NUMBER (____) _____

CHILDREN NUMBER (____) _____

MATERNAL GRANDMOTHER: _____

MATERNAL GRANDFATHER: _____

PATERNAL GRANDMOTHER: _____

PATERNAL GRANDFATHER: _____

HAS ANY BLOOD RELATIVES HAD? WHICH RELATIVE?

Cancer (Type) _____

Diabetes? _____

Heart Disease? _____

Stroke? _____

Bleeding Problems? _____

Gout? _____

High Blood Pressure? _____

IMMUNIZATIONS: APPROXIMATE DATE(S)

When was your last tetanus / Adacel shot? _____

Have you had the Hepatitis A vaccine?	YES / NO _____
Have you had the Hepatitis B vaccine?	YES / NO _____
Have you had the Pneumococcal vaccine?	YES / NO _____
Did you have a complete series of immunizations as a child?	YES / NO _____
Have you had the Gardasil (HPV) vaccine?	YES / NO _____
Have you had the Shingles / Zostovax vaccine?	YES / NO _____
Have you had the Meningococcal vaccine?	YES / NO _____
Other travel vaccines?	YES / NO _____

SOCICAL HISTORY

ARE YOU: SINGLE MARRIED DIVORCED SEPARATED WIDOWED (PLEASE CIRCLE)

DO YOU LIVE WITH YOUR PARTNER? YES / NO

DO YOU HAVE CHILDREN? YES / NO HOW MANY? _____ HOW OLD? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES / NO HOW MANY DRINKS A WEEK? _____

HAVE YOU EVER BEEN TOLD YOU DRINK TOO MUCH YES / NO

DO YOU SMOKE? YES / NO

HOW MANY CAFFENIATED BEVERAGES DO YOU HAVE EACH DAY? _____

DO YOU WEAR SEAT BELTS? YES / NO

OCCUPATION? _____

DESCRIBE YOUR JOB STRESS? HIGH _____ MEDIUM _____ LOW _____

DO YOU TRAVEL OUT OF THE COUNTRY? YES / NO

DO YOU EXERCISE? YES / NO HOW MANY TIMES A WEEK? _____

HOW WOULD YOU DESCRIBE YOUR DIET? GREAT GOOD OK LOTS OF ROOM TO IMPROVE