***This 6-page form takes about 15 minutes to complete. If you are unsure of any areas, it is fine to leave them blank and you may discuss it with your physician.**

Today's Date: _____ Phone number: _____

Name: _____ Date of birth: _____

MARITAL STATUS (circle one) SINGLE MARRIED DIVORCED WIDOWED

OCCUPATION: _____

EDUCATION (# YEARS): _____

PRIMARY PHYSICIAN: _____

ADVANCE CARE PLANNING: Do you have Health Care Power of Attorney? NO YES

Do you have a Living Will? NO YES

If yes, please bring a copy to your 1st appointment.

PRESENT MEDICAL CONCERNS:

ISSUES YOU WOULD LIKE TO ADDRESS AT YOUR FIRST APPOINTMENT:

***A nurse may call to assist you with your specific concerns or to help you make an appointment**

ALLERGIES: (Food and/or Medication) List specific allergen and specific reaction (e.g. Amoxicillin causes hives and itching):

NONE: ☐

MEDICATIONS: Include prescription and over-the-counter taken on a CONSISTENT basis (e.g. Ranitidine 150 mg twice daily):

Medication:	Dose:	Directions/Times Per Day:	NONE: ☐
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

PAST SURGICAL HISTORY (List surgery, date, hospital/location - e.g. wisdom tooth extraction; July 1, 2011; Dr. Molar):

1) _____
2) _____
3) _____
4) _____

HOSPITALIZATIONS (List reason, date and hospital/location):

1) _____
2) _____
3) _____
4) _____

TOBACCO USE (check one):

NEVER SMOKED: _____
CURRENT EVERY DAY SMOKER: _____
CURRENT SOME DAY SMOKER: _____
FORMER SMOKER: _____
EXPOSURE TO SECONDHAND SMOKE: _____
Date quit: _____ Years smoked: _____

Type (check all that apply):

CIGARETTES: _____
PIPE: _____
CHEW: _____
SNUFF: _____
CIGARS: _____
Packs per day: _____

Comment:

ALCOHOL USE (circle one): NO YES

Type: _____ Drinks per week: _____

Comment:

ILLICIT DRUG USE (circle one): NO YES

Type: _____ Times per week: _____

Comment:

SEXUAL ACTIVITY (circle those that apply):

Partners: Male(s) Female(s) NOT CURRENTLY / NO / YES

Birth control or other contraception: _____

Comments:

Are you currently, or have you ever been, in a relationship where you were physically hurt, threatened, pressured to have sexual contact or made to feel afraid? NO YES

If yes (circle one): CURRENTLY / IN THE PAST

PREGNANCY HISTORY: Currently pregnant? NO YES

Total # of pregnancies:_____ Total # living children:_____

Full-term births:_____ Premature (under 37 weeks):_____ Ectopic:_____ Miscarriage:_____ Abortion:_____ Stillborn:_____

ACTIVITIES OF DAILY LIVING (circle answers):

Military service:	NO	YES	Special diet:	NO	YES
Blood transfusion:	NO	YES	Back care:	NO	YES
Caffeine concern:	NO	YES	Exercise:	NO	YES
Use per week:	_____		Type:	_____	
Occupational exposure:	NO	YES	Times per week:	_____	
Hobby hazards:	NO	YES	Bike helmet:	NO	YES
Sleep concern:	NO	YES	Seatbelt:	NO	YES
Stress concern:	NO	YES	Self-exams (breast, testicular):	NO	YES
Weight Concern:	NO	YES			

Tests:	Date of last mammogram		or N/A	Where performed?:	
	Date of last colonoscopy		or N/A	Where performed?:	
	Date of last pap smear		or N/A	Where performed?:	
	Date of last bone density		or N/A	Where performed?:	

PERSONAL CURRENT AND PAST MEDICAL HISTORY (circle answers):

		Year Diagnosed		
Breast cancer:	NO/YES		COMMENT:	
Ovarian cancer:	NO/YES		COMMENT:	
Uterine cancer:	NO/YES		COMMENT:	
Colon cancer:	NO/YES		COMMENT:	
Prostate cancer:	NO/YES		COMMENT:	
Other cancer (list type):	NO/YES		COMMENT:	
High blood pressure:	NO/YES		COMMENT:	
Stroke/CVA:	NO/YES		COMMENT:	
Heart disease/heart attack:	NO/YES		COMMENT:	
High cholesterol:	NO/YES		COMMENT:	
Diabetes (list type 1 or 2):	NO/YES		COMMENT:	
Thyroid disease:	NO/YES		COMMENT:	
Alcohol dependency:	NO/YES		COMMENT:	
Drug dependency:	NO/YES		COMMENT:	
Depression:	NO/YES		COMMENT:	
Anxiety:	NO/YES		COMMENT:	
Other psychiatric concerns:	NO/YES		COMMENT:	
Memory concerns:	NO/YES		COMMENT:	
Allergies:	NO/YES		COMMENT:	
Asthma:	NO/YES		COMMENT:	
Osteoporosis:	NO/YES		COMMENT:	
Sickle cell disease:	NO/YES		COMMENT:	
Autoimmune disease:	NO/YES		TYPE:	
Aneurysm:	NO/YES		LOCATION:	
OTHER:				

Are you adopted? _____ YES _____ NO

If no, please check the box associated with family members who currently have or have had the following medical conditions:

If yes, but you know history of any blood relatives, please check the appropriate boxes below.

Be sure to complete front and back of this form.

Relationship:	**Name:**	**STATUS: (alive/ deceased)**	Hypertension	Coronary/Heart	Aneurysm	Stroke/CVA	Cholesterol Disorder	Diabetes Mellitus	Thyroid Disease	Allergies/Asthma	Immunologic Disorder	Autoimmune Disease	Cancer Breast	Cancer Ovarian	Cancer Uterine	Cancer Colon	Cancer Prostate	Cancer Other	Gastrointestinal Disease	Kidney Disease
Father		A / D																		
Mother		A / D																		
Son(s):		A / D																		
		A / D																		
		A / D																		
Daughter(s):		A / D																		
		A / D																		
		A / D																		
Sister(s):		A / D																		
		A / D																		
		A / D																		
Brother(s):		A / D																		
		A / D																		
		A / D																		
Mom's Mother (MGrandmother)		A / D																		
Dad's Mother (PGrandmother)		A / D																		
Mom's Father (MGrandfather)		A / D																		
Dad's Father (PGrandfather)		A / D																		
Mom's Sisters (MAunt)		A / D																		
Dad's Sisters (PAunt)		A / D																		
Mom's Brothers (MUncle)		A / D																		
Dad's Brothers (PUncle)		A / D																		
Other		A / D																		

Relationship:	Name:	Strabismus / Lazy Eye	Deafness	Anemia	Bleeding Disorder	Sickle Cell Disease	Neurological Disorder	ADD/ADHD	Learning Disablity	Depression	Anxiety	Psych Other	Dementia	Alcohol/Drug	Osteoporosis	Other	Unknown FHx
Father																	
Mother																	
Son(s):																	
Daughter(s):																	
Sister(s):																	
Brother(s):																	
Mom's Mother (MGrandmother)																	
Dad's Mother (PGrandmother)																	
Mom's Father (MGrandfather)																	
Dad's Father (PGrandfather)																	
Mom's Sisters (MAunt)																	
Dad's Sisters (PAunt)																	
Mom's Brothers (MUncle)																	
Dad's Brothers (PUncle)																	
Other																	