Family Practice New Patient Intake Form

Reason for Visit_____

Past Medical History:

Please review the list below and check any problems you have had now or in the past

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD/ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol Abuse		Freq Sinus Infections		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety Disorder		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar Disorder		Heart Attack		Rosacea	
Blood Clot		Heart Condition (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A, B, C)		Seizures	
Cancer (What kind)		High Blood Pressure		Sexually Trans. Disease	
Chronic Bronchitis		High Cholesterol		(specify)	
Crohn's Disease or IBS		Kidney Disease		Stomach Ulcers	
Colon Polyps		Kidney Infections		Stroke	
Depression		Kidney Stones		Tuberculosis	
Diabetes		Lupus		Thyroid Disease	
Diverticulitis		Melanoma or Skin Cancer		Ulcerative Colitis	
Drug Abuse		Migraines		Warts	
Eating Disorder		Osteoarthritis			

Other medical problem not on list:_____

Please check or list all of the **SURGERIES** you have had:

	Type of surgery:	Year
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of surgery:	Year
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Mastectomy/Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	
	Other (specify)	

Current Medications:(please include over the counter medications and food supplements)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes No**

Drug Name:	Reaction:

NAME: _____

For Women:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	Y N
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family Member:
	Heart Disease/attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family Member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer	

Any other illness in the family not listed?

_____

Social History:

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed

Highest Level of Education: <6th grade Jr. High High School College Graduate school Professional

Occupation:

_____

If you have any children, please list their names and ages:

_____

Health Habits:

1. Do you **smoke currently?** **Yes No** If so, how much? ___ cig/d # of years smoking ___

   If no, did you **smoke in the past?** **Yes No** How many years? __ How much? ___pk/d quite date _____

   Are you **exposed to smoke?** **Yes No**

   Any other **tobacco use?** **Yes No** type: **Cigars chewing tobacco snuff other**

2. Do you drink **caffeine?** **Yes** **No** If so, how much?

_____

3. Do you drink **Alcohol?** **Yes** **No** What kind? Beer Wine Liquor Other:_____

If so, how many times per week? _____ month? _____ year? _____

Have you ever had a problem with alcohol in the past? (legal or social)

_____

4. Have you ever used **street drugs?** **Yes** **No**

Which ones? Marijuana IV drugs amphetamines cocaine heroin downers inhalants other _____

Are you still using? **Yes** **No** Which ones? _____

5. Are you **sexually active** (in the last year)? **Yes** **No**

If yes circle all that apply: **1 partner** **multiple partners**

Male partner(s) **Female partner(s)**

Which birth control do you or your partner use? None condoms the pill vasectomy/tubal other_____

6. Do you **exercise?** **Yes** **No** If so, what type and how often?

_____

7. Do you eat out at **restaurants** weekly? **Yes** **No** Times per week _____

8. How many servings of **fruits and vegetables** do you get per day? 0 1 2 3 4 5 >5

9. Do you take a **calcium supplement**? **Yes** **No** Number of dairy servings per day: ___ (milk cheese yogurt..)

10. Do you wear a **seatbelt**? **Yes** **No**

11. Do you have a **living will** (do not resuscitate, medical power of attorney)? **Yes** **No** Please ask for info

12. Is there concern for your **safety?** (emotional, physical, or sexual abuse)? **Yes** **No**

NAME: _____