associates in PRIMARY CARE

Name: _____

DOB: _____

New Patient History

Current Medications and Supplements (attach additional sheet if necessary)

Medication Name	Dosing	Frequency

Allergies (attach additional sheet if necessary)

Medication	Reaction	Date of onset

Past Surgeries

Procedure	Date (Month/Year)

Other Healthcare Providers/Specialists

Name	Reason

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Women

Date of last menstrual period	
Date of last PAP smear	Any history of abnormal PAP? ▢ No ▢ Yes
Date of last mammogram	
Date of last bone density/DEXA	

Health Maintenance

Date (Month/Year)	
	Colonoscopy • Sigmoidoscopy • Cologuard (circle one)
	Pneumovax vaccine
	Prevnar 13 vaccine
	Tetanus vaccine
	Shingles (Zostavax • Shingrix) (circle one)
	Covid vaccine • Number of total doses: _____
	Influenza vaccine

Social History

Marital status: ▢ Single ▢ Married ▢ Divorced ▢ Separated ▢ Widowed

Number of children: _____

Tobacco use:

Current: ▢ No▢ Yes

If yes - How many years? _____ Packs per day? _____ Type? _____

Past: ▢ No ▢ Yes

If yes - How many years? _____ Packs per day?_____ Quit date? _____

Alcohol use: ▢ No ▢ Yes

If yes - number of drinks per day? _____ per week? _____

Drug use/: ▢ No ▢ Yes

If yes - Type? _____ Frequency? _____

Number of caffeinated beverages per day? _____

Employment: ▢ Currently Employed ▢ Unemployed ▢ Retired

Type of work? _____ Any known exposure? _____

Exercise:

Type? _____ Days per week? _____ Minutes? _____

Family History:

Have any of your family members (parent, sibling, child) had any of the following problems?

X	Condition	Family Member	X	Condition	Family Member
	Heart disease/heart attack			Osteoporosis	
	Stroke			Breast cancer	
	Diabetes			Colon cancer	
	High blood pressure			Ovarian cancer	
	High cholesterol			Prostate cancer	
	Thyroid disease			Other cancer	
	Depression/Mental illness			Other medical condition:	
	Alcoholism				

Past Medical History:

Please check any of the problems you have had - current or past

Alcohol/drug abuse		Diabetes		Migraines	
Anemia		Gallstones		Osteoarthritis	
Anxiety disorder		Glaucoma		Osteoporosis	
Arrhythmia/a.fib		Gout		Prostate issues	
Asthma		Heart attack		Reflux/heartburn	
Blood clot		Heart disease/failure		Rheumatologic disorder	
Cancer		Hepatitis (A, B, or C?)		Skin condition	
COPD		High blood pressure		Seasonal allergies	
Bowel disease		High cholesterol		Ulcer	
Colon polyps		Kidney disease		Stroke	
Depression/Bipolar disorder		Kidney stones		Thyroid disease	