

Cornerstone Family Practice New Patient Health History

NAME: _____

DATE: _____

AGE: _____

MEDICATIONS: Please list all prescription and OTC meds. with dosages.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ALLERGIES: Please list drug, food and environmental allergies & type of reaction.

1.	4.
2.	5.
3.	6.

PAST MEDICAL HISTORY:

Medical : Please check any medical problems you've had and the date or year.

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Acne
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Problems
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Cancer: Type _____
<input type="checkbox"/> Drug or Alcohol Problems
<input type="checkbox"/> Eating Disorder/ Anorexia or Bulemia
<input type="checkbox"/> Gallbladder Problems
<input type="checkbox"/> Heart Disease/ Attack
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Liver Disease/Hepatitis
<input type="checkbox"/> Migraines
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Pre-cancerous Skin Lesions
<input type="checkbox"/> Rheumatic Heart Disease
<input type="checkbox"/> Seizures
<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Tubal or Pelvic Infections
<input type="checkbox"/> Ulcer
Other Major Medical Problems not listed:

Women Only:
of Pregnancies _____ # of Deliveries _____
of Miscarriages/Abortions _____
Last Menstrual Period (first day) _____ |
|--|--|

Surgical: Please list prior surgeries and dates.

1.
2.
3.
4.
5.

Routine Health Maintenance: Please list date & result of your last exam.

Cholesterol Test
Colon Cancer Screen (Stool cards or Flexible Sigmoidoscopy)
Eye Exam
Mammogram
Pap Smear
Prostate Cancer Screen (PSA)

Immunizations: Please check if you've had these vaccines and the Date.

<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Pneumonia Shot (Pneumovax)
<input type="checkbox"/> Hepatitis B Series	<input type="checkbox"/> Tetanus Booster
<input type="checkbox"/> Flu Shot (Influenza)	

SOCIAL HISTORY:

Primary Occupation: _____

Current Household Members: Please note relationship to you and age of children.

1.	4.
2.	5.
3.	6.

Exercise: None 1-2x/week 3-4x/week 5-7x/week

Activity? _____

Alcohol Use: None Occasional(1-2/week) Moderate (3-5/week)

Heavy (>6/week) Beer Wine Hard Liquor

Do you feel you need to quit or cut down?

Tobacco Use: Non-Smoker Smoker Ex-Smoker : Quit Date _____

Packs per day _____ Years of Smoking _____

Drug Use:

PRESENT Use: Marijuana Cocaine Speed IV Drugs

PAST Use: Marijuana Cocaine Speed IV Drugs

Sexual History: Preference? Men Women Both

Currently Active? yes no **Condom Use?** yes no

Birth Control Use? yes no **Type?** _____

Sexually Transmitted Diseases? Type and Date _____

FAMILY HISTORY: Please list family members with the following diseases

Note relationship to you and whether mother's (M) or father's (F) side of your family.

Alcohol/Drug Abuse	Skin Cancer
Asthma/Allergies	Thyroid Cancer
Birth Defect/Genetic Disease	Depression/Psychiatric Problems
Breast Cancer	Diabetes
Cervical Cancer	Heart Disease/Attack
Colon Cancer	High Blood Pressure
Lung Cancer	High Cholesterol
Ovarian Cancer	Migraines
Prostate Cancer	Stroke