New Patient Assessment- Adult

Print Name:_____ DOB:_____ Today's Date:_____

Social History

Alcohol Use: **NONE** **1-2 per day/week** **3-5 per day/week** **More than 6 per day/week**

Do you drink: Beer Wine Hard Alcohol Do you think you need to quit or cut down: Y N

Drug Use: **Drug and frequency of use**_____

Exercise: **NONE** **1-2 times/week** **3-5 times/week** **More than 6 days per week**

Type(s) of exercise:_____

Tobacco Use: **NONE** **1-2 times/week** **3-5 times/week** **More than 6 times per week**

How many packs per day/week_____ Are you interested in quitting: Y N

Do you JUUL or Vape: YES NO Frequency:_____

Safety

Do you wear seatbelts in the car?_____

Do you have active smoke detectors in your home?_____

Do you wear a helmet when riding a bike or motorcycle?_____

Do you have guns in the home?(optional)_____

Sexual Activity

Are you currently active?_____ New partner?_____Using condoms?_____

Other forms of birth control used:_____Sexual Preference: Male Female Both

History of STD: Type and Date_____

Pregnancy History

Number of pregnancies_____ Number of live births_____Number of miscarriages/abortions_____

Date of last menstrual period (First day):____/____/____

Allergies-Please list medication/food allergies and their reaction.

(TURN OVER)

Current Medication(s) List

NAME OF MEDICATION	DOSE	FREQUENCY

Current Over the Counter Medications or Vitamins you take on a regular basis.

Pharmacy Information: Local_____**Phone #**_____

Mail Order: _____**Phone #**_____

Personal History

Do you have a personal history of Diabetes:_____ Last A1C:_____Type 1 or 2 _____

Do you have a personal history of depression or post -partum depression:_____

Are you currently under the care of a Psychologist or Psychiatrist:_____

If yes, please provide the name and phone number of your provider below-

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Are you currently feeling anxious or depressed:_____Do you feel irritable:_____

Do you have a feeling of hopelessness:_____Feeling of doom:_____

Do you feel overwhelmed: _____Feel like you have no control:_____

Are you current on your vaccines?_____

Flu:_____ Date:_____

Pneumonia:_____Date:_____

Hep A:_____Date:_____

Hep B:_____Date:_____

Tetanus:_____Date:_____

Surgical History- List surgeries and approximate dates.

Hospitalizations- List condition(s) you were treated for and dates of hospitalization.

Current Household Members-Name and relation to you:

(TURN OVER)

Do you have a personal history of any of the following? Please circle all that apply:

Abnormal PAP smear	**Acne**	**Anemia**	**Asthma**
Back Problems	**Blood Transfusion(s)**	**Cancer-Type:**	**Drug or Alcohol Issues**
Eating Disorder(s)- Anorexia or Bulimia	**Gallbladder Issues**	**Heart Disease/Attack**	**Heart Murmur**
High Blood Pressure	**High Cholesterol**	**Kidney Stones**	**Kidney Disease**
Liver Disease/Hepatitis	**Migraines**	**Mitral Valve Prolapse**	**Pneumonia**
Pre-Cancerous skin lesions	**Rheumatic Heart Disease**	**Seizures**	**Suicide Attempt**
Thyroid Problems	**Tubal or Pelvic Infections**	**Ulcer(s)**	**Other:**

Routine Health Maintenance- Please list the date and result of your last exam.

Cholesterol Test:_____ Colon Cancer Screening:_____

Eye Exam:_____ Mammogram:_____

PAP Smear:_____ Prostate Cancer Screening:_____

Family History- Please note if on Mother's side or Father's side

Alcohol/Drug Abuse M F	Asthma/Allergies M F	Birth Defect(s) M F
Genetic Disease(s) M F	Breast Cancer M F	Cervical Cancer M F
High Cholesterol M F	Skin Cancer M F	Thyroid Cancer M F
Diabetes M F	Depression/Psychiatric Problems M F	Neurological Issues M F
Lung Cancer M F	Ovarian Cancer M F	Migraines M F

Is there anything you feel we should know that would help us meet or exceed your medical needs?