

NEW PATIENT INFORMATION (ADULT)

Name: _____ Date: _____

1. Medication

List any Medications you cannot take and why: _____
 List the medicines you are currently taking:

Medication (name / dose)	Medication (name / dose)	Medication (name / dose)

2. Illnesses:

Check if you have or have had any of the following illness:

Rheumatic Fever	Pneumonia	Cancer	Tuberculosis
Heart Trouble	Emphysema	Menstrual Problems	Glaucoma
High Blood Pressure	Ulcers	Stroke	Colitis
Asthma	Hepatitis	Epilepsy / Convulsions	Blood Clots
Hay Fever	Urinary Tract Problems	Nervous or Mental Illness	Sexual Problems
Diabetes	Venereal Disease	Skin Problems	Thyroid Problems
Anemia	Arthritis	Other (specify)	

3. Surgeries / Hospitalizations / Injuries:

List any surgeries, injuries or operations:

Surgery, Injury, or Reason for hospitalization	Year or Age	Hospital	Doctor's Name

4. Social Habits:

Alcohol Consumption	Tobacco Usage	Exercise (list the exercise you do regularly)	Seat belt usage
Never	Cigarettes		Always
3-10 times / year	Packs/day:		Sometimes
Once a week	Age began:		Never
2-3 times a week	Cigars		
Daily	Pipe		
Beer wine liquor (please circle)	Chew		

5. Preventive Health History:

Please enter the dates for the following:

Tetanus Shot? _____ Pneumonia Shot? _____ TB Test? _____ Flu Shot? _____
 Mammogram? _____ Prostate Cancer Test? _____ Dexa Scan? _____ PAP? _____
 Colon Cancer Test? _____ (type) _____ Cholesterol Check? _____

6. Family Medical History

Check if any of these diseases have occurred in blood relatives. List those who have had it.

Diabetes		Epilepsy		Mental Illness	
High Blood Pressure		Arthritis		Cancer (type?)	
Anemia		Allergy			
Bleeding Disorder		Asthma		Heart Trouble	
Thyroid Disease		Stroke		Other (list)	
Tuberculosis		Suicide			

Please list any relatives who have died and the cause of death:

Relative	Cause of Death	Age at Death

7. Personal History

List those who are living at home with you (spouse, children, parent, ect): _____
 Last grade of education? _____ Occupation? _____ Spouse's Occupation? _____
 Hobbies? _____ How long have you lived in Idaho? _____

8. Woman's History

Age began menstrual periods: _____ Number of pregnancies? _____ miscarriages? _____ abortions: _____
 Describe your menstrual cycle: _____ Age at Menopause? _____