New Patient Information Form

Name _____ Age _____ Date of Birth _____ Date _____/_____/_____

Reason for visit: ☐ Annual Exam ☐ Problem Visit (please describe) _____

Please list all your MAJOR MEDICAL ILLNESSES: ☐ **NONE** _____

1. _____ 3. _____

2. _____ 4. _____

When was your last PAP SMEAR? _____

Do you have any history of ABNORMAL PAP SMEARS? ☐ YES ☐ NO

Have you ever had a BONE DENSITY STUDY? ☐ YES ☐ NO

If YES, when was your last one? _____ Was it normal? ☐ YES ☐ NO

Have you ever had a MAMMOGRAM? ☐ YES ☐ NO

If YES, when was your last one? _____ Was it normal? ☐ YES ☐ NO

Have you ever had a COLONOSCOPY? ☐ YES ☐ NO

If YES, when was your last one? _____ Was it normal? ☐ YES ☐ NO

If you are over the age of 65, have you ever received a pneumonia vaccine? ☐ YES ☐ NO

Have you gone through MENOPAUSE? ☐ YES ☐ NO

If YES:

- How old were you when you stopped having periods? _____
- Are you on any HORMONE REPLACEMENT THERAPY? ☐ YES ☐ NO
- Do you have any significant MENOPAUSAL SYMPTOMS? ☐ YES ☐ NO

☐ hot flashes ☐ night sweats ☐ vaginal dryness ☐ other _____

Are you currently SEXUALLY ACTIVE? ☐ YES ☐ NO ☐ With Men ☐ With Women

If YES, HOW DO YOU PREVENT PREGNANCY? _____

Have you ever been diagnosed with any of the following SEXUALLY TRANSMITTED DISEASES?

☐ HERPES ☐ HIV/AIDS ☐ SYPHILIS ☐ CHLAMYDIA ☐ GONORRHEA

Please list all your prior SURGERIES:

Surgery	Year	Surgery	Year
1. _____	_____/_____/_____	5. _____	_____/_____/_____
2. _____	_____/_____/_____	6. _____	_____/_____/_____
3. _____	_____/_____/_____	7. _____	_____/_____/_____
4. _____	_____/_____/_____	8. _____	_____/_____/_____

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AdvancedHEALTH

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MEDICATIONS

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis:

Medication	Dose	Medication	Dose
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

(If you are on more than 8 medications please review the remainder with the nurse in the exam room)

Please list all the OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS you take on a regular basis:

1. _____ 3. _____

2. _____ 4. _____

ALLERGIES

Please list all ALLERGIES TO MEDICATIONS:

Medication	Reaction (rash, shortness of breath, etc)
1. _____	_____
2. _____	_____

Please list any SEVERE FOOD or ENVIRONMENTAL ALLERGIES you have: _____

Are you allergic to LATEX? ☐ YES ☐ NO

FAMILY HISTORY

M= Mother **F**= Father **S**= Sister **B**= Brother **MGM**= Maternal grandmother **MGF**= Maternal grandfather
PGM= Paternal grandmother **PGF**= Paternal grandfather

1.	High blood pressure	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
2.	Diabetes	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
3.	Heart disease	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
4.	Breast cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
5.	Ovarian cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
6.	Colon cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
7.	Thyroid disorder	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
8.	Osteoporosis	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
9.	Blood clotting disorder	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
10.	Deep venous thrombosis *(DVT – blood clot deep in leg)*	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
11.	Autoimmune disorders *(such as lupus, rheumatoid arthritis, etc)*	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
12.	Other _____								

At what age did you START YOUR PERIODS? _____

If you are still having periods:

- When was your LAST MENSTRUAL PERIOD? _____
- Are your periods ☐ REGULAR or ☐ IRREGULAR?
- How many DAYS are there BETWEEN your cycles? _____
- How many DAYS do your periods LAST? _____
- Are your periods: ☐ LIGHT ☐ MODERATE ☐ HEAVY
- Do you frequently SPOT between periods? ☐ YES ☐ NO
- Do you pass large CLOTS with your periods? ☐ YES ☐ NO _____
- Describe your CRAMPS: ☐ None ☐ MILD ☐ MODERATE ☐ SEVERE _____

Do you drink ALCOHOL? ☐ Rarely ☐ Occasionally ☐ Daily ☐ Never _____

Do you smoke? ☐ YES ☐ NO

If YES, check any that apply: ☐ CIGARETTES ☐ VAPING ☐ E-CIGARETTES ☐ MARIJUANA

Do you use any ILLICIT SUBSTANCES? ☐ YES ☐ NO _____

Are you ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED?

Do you EXERCISE? ☐ Regularly ☐ Occasionally ☐ Never

Are you EMPLOYED outside the home? ☐ YES ☐ NO

If YES, what type of work do you do (if you are a student please include this information as well)?

_____

Have you ever been a victim of DOMESTIC VIOLENCE? ☐ YES ☐ NO

Have you ever been PREGNANT? ☐ YES ☐ NO

If YES:

How many TIMES have you been pregnant? _____ How MANY children have you delivered? _____

How many LIVING CHILDREN do you have? _____

Have you delivered any children PREMATURELY (before 37 weeks)? ☐ YES ☐ NO If YES, how many? _____

Have you had any MISCARRIAGES? ☐ YES ☐ NO If YES, how many? _____

Have you had any ELECTIVE ABORTIONS? ☐ YES ☐ NO If YES, how many? _____

Please **check** any SIGNIFICANT SYMPTOMS you currently experience: ☐ **NONE**

- **CONSTITUTIONAL:** ☐ weight gain ☐ weight loss ☐ fatigue ☐ loss of appetite ☐ fevers ☐ chills ☐ other _____
- **EYES:** ☐ blurred vision ☐ eye pain ☐ discharge from eye ☐ other _____
- **HEAD & NECK:** ☐ severe headaches ☐ sore throat ☐ nasal discharge ☐ nose bleeds ☐ decreased hearing ☐ lightheadedness ☐ other _____
- **BREAST:** ☐ lumps ☐ tenderness ☐ nipple discharge ☐ other _____
- **CARDIOVASCULAR:** ☐ chest pain ☐ irregular heartbeat ☐ fainting spells ☐ other _____
- **RESPIRATORY:** ☐ shortness of breath ☐ cough ☐ wheezing ☐ other _____
- **GASTROINTESTINAL:** ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ heartburn ☐ abdominal pain ☐ blood in stools ☐ incontinence of stools ☐ hemorrhoids ☐ other _____
- **GENITOURINARY:** ☐ urinary frequency ☐ pain with urination ☐ blood in urine ☐ urinary incontinence ☐ difficulty urinating ☐ vaginal discharge ☐ pain with intercourse ☐ bleeding with intercourse ☐ significant PMS ☐ other _____
- **SKIN:** ☐ rash ☐ itching ☐ acne ☐ abnormal hair growth ☐ other _____
- **NEURO:** ☐ headaches ☐ weakness ☐ numbness ☐ other _____
- **MUSCULOSKELETAL:** ☐ joint pain ☐ joint swelling ☐ muscle weakness ☐ muscle pain ☐ other _____
- **ENDOCRINE:** ☐ increased thirst ☐ increased urination ☐ hair loss ☐ heat intolerance ☐ cold intolerance ☐ other _____
- **PSYCHIATRIC:** ☐ anxiety ☐ depression ☐ confusion ☐ other _____
- **HEMATOLOGIC:** ☐ easy bruising ☐ easy bleeding ☐ lymph node enlargement ☐ other _____
- **ALLERGIC:** ☐ sinus allergies ☐ skin allergies ☐ other _____

I have filled out this form completely and to the best of my ability.

Signature _____ Date _____/_____/_____