New Patient Registration and Health History

Name (First, MI, Last):	**Gender:**	**DOB:**
Emergency Contact Name:	**Relationship:**	
Emergency Contact Phone:		
Previous Clinic/Medical Provider:	**Date of Last Exam:**	
Other Medical Providers (cardiologist, dermatologist, dentist, etc):		

Personal Health History

Most Recent Health Maintenance (list date and result):	DEXA Scan	Colonoscopy (or Stool Test)
	Mammogram	Vaccines:
	Pap Smear	Other:
Past Medical History (Circle all that apply):		
ADHD	Dementia	Liver Disease or Hepatitis
Alcoholism	Depression	Macular Degeneration
Allergies, seasonal	Diabetes Type 1/Type 2	Neuropathy
Anemia	Diverticulitis	Osteopenia/Osteoporosis
Anxiety	DVT (Blood Clot)/ PE (pulmonary embolism)	Parkinson’s Disease
Arrythmia (irregular heartbeat)	Eating Disorder	Peripheral Vascular Disease
Arthritis	GERD (acid Reflux)	Psoriasis
Asthma	Headaches/Migraines	Rheumatoid Arthritis
Back Pain/Back Injury	Heart Disease	Seizure Disorder
Bipolar Disorder	Heart Attack (MI)	Sleep Apnea
Bladder Problems/Incontinence	Hernia	Stroke
Bleeding Problems	Hypertension (High Blood Pressure)	Thyroid Disease
Cancer (list type)	High Cholesterol	Ulcer
COPD/Emphysema	Irritable Bowel Syndrome	**Other:**
Crohn’s Disease or Ulcerative Colitis	Kidney Disease or Kidney Stones	**Other**

Allergies

Medication/Product/Environmental/Food	Reaction	Medication/Product/Environmental/Food	Reaction

Current Medication (Prescriptions, over-the-counter drugs, vitamins and supplements		
Medication Name	Strength/Dose	Frequency

Surgeries, Procedures and Hospitalizations		
Month/Year	Surgery/Procedure/Hospitalization	Hospital

Family Health History				
Status: Alive (A) Deceased (D) Unknown(U), please check box if history is unknown or healthy, list other health conditions				
☐ **Unknown Healthy History**				
	Age/Status	**Unknown**	**Healthy**	**Significant Health Conditions**
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brother				
Sister				
Child				
Child				

Additional Information:

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Social History and Health Habits	
Education Level: ☐ Elementary ☐ High School/GED ☐ Vocational ☐ College ☐ Graduate/Professional	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation:	
Exercise	☐ No regular exercise/sedentary
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
Weight/Diet	Do you have any concerns about your weight? ☐ Yes ☐ No
	If yes, what is your concern?
	What have you tried to maintain a healthy weight? ☐Diet ☐Exercise ☐Medication ☐Surgery
	Do you eat regular meals daily? How many? Snacks?
Caffeine Intake	☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Other
	# of cups, bottles, cans per day?
Alcohol Use:	Do you drink Alcohol? ☐Yes ☐No ☐Past
	If yes, what kind?
	How many drinks per day ________ week________ month_________
Recreational Drug Use:	Do you use recreational drugs? ☐Yes ☐No ☐Past
	If yes, what type?
Tobacco Use:	Do you use Tobacco or Nicotine containing products (chew, e-cigarettes, cigars)? ☐Yes ☐ No
	☐ Cigarettes – #packs/day ☐ Chew #/day ☐ Pipe #/day
	# of years or year quit
	Are you interested in quitting? ☐Yes ☐ No
Sexual Health	Are you currently sexually active? ☐Yes ☐No
	Any concerns for Sexually Transmitted Infections/Diseases (STIs/STDs)? ☐Yes ☐No
	Current form of contraception?
Personal Safety	Do you have an Advance Directive or Living Will? ☐Yes ☐No
	Do you have frequent falls? ☐Yes ☐No
	Do you feel safe at home? ☐Yes ☐No
	Do you have vision or hearing concerns? ☐Yes ☐No
	Any financial issues that impact your ability to manage your health? ☐Yes ☐No
	Any cultural or religious beliefs that are important to your healthcare? ☐Yes ☐No

Additional Comments:

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Patient (or Parent/Guardian) Signature: ____

Today's Date: ______________