NEW PATIENT HEALTH ASSESSMENT

Patient Name ____ Date of Birth ___________________

In order to help us deliver quality health care, please provide responses to the following personal history questions. You should feel free to discuss any questions you have concerning these items with your provider.

Do you have any particular health concerns that you would like to discuss with your provider?

____
____
____

PROBLEM LIST

Do you have any ongoing medical problems that are under treatment at the present? Examples: high blood pressure, diabetes, asthma, etc.

Condition	Date	Comments

PAST MEDICAL HISTORY

Have you had any prior medical conditions that are now resolved? Examples: pneumonia, broken bones, strain/sprain etc.

Condition	Date	Comments

PAST SURGICAL HISTORY

Procedure	Date	Comments

MEDICATION LIST

Please list **ALL MEDICATIONS** that you are currently taking including doses. Don't forget inhalers, nasal sprays, skin creams and over the counter medications.

Medication	Dosage	Frequency

LIST ADDITIONAL MEDICATIONS ON A SEPARATE SHEET OF PAPER

ALLERGIES

Do you have any **ALLERGIES** to medications, foods, or other substances?

Agent	Reaction	Date	Comments

HEALTH MAINTENANCE	Date
Colonoscopy	
PSA	
Mammography	
Pap Smear	
DEXA Scan	
Lipids (Cholesterol)	

IMMUNIZATION	Date
Tetanus Vaccine	
Influenza Vaccine	
Pneumonia Vaccine	
Shingles Vaccine	
Hepatitis A Vaccine	
Hepatitis B Vaccine	

Previous Primary Care Physician: ____

Address: ____

Names/Specialties/Locations of Other Physicians Providing Your Treatment:

____

____

____

____

____

REVIEW OF SYSTEMS

SKIN
- [ ] pigmentation
- [ ] rash
- [ ] scaling
- [ ] itching
- [ ] bruising
- [ ] lumps or bumps
- [ ] hair changes
- [ ] nail changes
- [ ] psoriasis
- [ ] rosacea
- [ ] seborrhea
- [ ] skin malignancy
- [ ] recurrent herpes

EYES
- [ ] cataracts
- [ ] visual blurring
- [ ] double vision
- [ ] glaucoma
- [ ] eye pain
- [ ] color blindness
- [ ] glasses or contacts
- [ ] blind spots
- [ ] dry eye
- [ ] conjunctivitis
- [ ] inflammation
- [ ] visual loss
- [ ] blindness
- [ ] xanthelasma

EAR/NOSE/THROAT
- [ ] deafness
- [ ] tinnitus
- [ ] vertigo
- [ ] nose bleeds
- [ ] deviated septum
- [ ] frequent colds
- [ ] sinus trouble
- [ ] persistent sore throat
- [ ] tonsillitis
- [ ] bleeding gums
- [ ] dental problem
- [ ] sinusitis
- [ ] hoarseness

RESIRATORY
- [ ] cough
- [ ] persistent cough
- [ ] sputum
- [ ] coughing up blood
- [ ] shortness of breath
- [ ] wheezing

CARDIOVASCULAR
- [ ] palpitations
- [ ] rapid heartbeat
- [ ] irregular heartbeat
- [ ] chest pain
- [ ] chest pain with exertion
- [ ] shortness of breath at night
- [ ] shortness breath lying flat
- [ ] lower extremity edema
- [ ] cyanosis
- [ ] pain when walking
- [ ] phlebitis
- [ ] varicose veins

GASTROINTESTINAL
- [ ] difficulty swallowing
- [ ] dyspepsia
- [ ] vomiting blood
- [ ] abdominal pain
- [ ] excessive gas or bloating
- [ ] dark or tarry stools
- [ ] blood in the stool
- [ ] constipation
- [ ] diarrhea
- [ ] jaundice
- [ ] nausea
- [ ] vomiting
- [ ] abdominal cramps
- [ ] loose/frequent bowels

GENITOURINARY
- [ ] urinating at night
- [ ] difficulty with urination
- [ ] frequency
- [ ] hesitancy
- [ ] blood in the urine
- [ ] incontinence
- [ ] urgency
- [ ] erectile dysfunction

MUSCULOSKELETAL
- [ ] fracture
- [ ] back pain
- [ ] arthritis
- [ ] gout
- [ ] fibromyalgia
- [ ] muscular weakness
- [ ] nocturnal cramping
- [ ] joint pain

NEUROLOGIC
- [ ] headache/migraines
- [ ] fainting
- [ ] seizures
- [ ] paralysis
- [ ] numbness/tingling hands/feet
- [ ] involuntary movement
- [ ] tremor
- [ ] neuropathy
- [ ] benign positional vertigo

PSYCHIATRIC
- [ ] sleep disturbance
- [ ] anxiety
- [ ] difficulty with memory
- [ ] depression
- [ ] sexual difficulties
- [ ] marital problems
- [ ] abusive relationship
- [ ] excessive alcohol consumption
- [ ] illegal drug usage

HEMATOLOGI/LYMPHATIC
- [ ] anemia
- [ ] bleeding disorder
- [ ] bruising
- [ ] fever
- [ ] night sweats
- [ ] chills
- [ ] weight loss/gain
- [ ] swollen lymph nodes
- [ ] HIV risk factors
- [ ] allergies

ENDOCRINE
- [ ] goiter
- [ ] thyroid disorder
- [ ] diabetes
- [ ] osteoporosis
- [ ] hyperlipidemia

TOBACCO USE

- [ ] I have NEVER smoked
- [ ] I smoked in the past but I have QUIT
- [ ] I am exposed to PASSIVE smoke
- [ ] YES, I currently smoke

How much did or do you smoke? ☐ Packs/day

How long had or have you smoked? ☐ Years

When did you most recently quite? ☐ Date Quit

What kind of tobacco did/do you use?

- [ ] Cigarettes
- [ ] Pipe
- [ ] Cigar
- [ ] Snuff
- [ ] Chew

Comment ___________________________

ALCOHOL USE

- [ ] I don't consume alcohol
- [ ] I consume alcohol on occasion

How many drinks containing 0.5 oz. of alcohol do you consume per week?

- [ ] Can(s) of beer
- [ ] Glass(es) of wine
- [ ] Shot(s) of liquor

Comment ___________________________

DRUG USE

- [ ] I don't use drugs
- [ ] I use drugs on occasion

Please indicate your frequency of use per week for each substance:

- [ ] IV
- [ ] Cocaine
- [ ] Marijuana
- [ ] Other

Comment ___________________________

SEXUAL ACTIVITY

- [ ] I am not currently sexually active
- [ ] I have never been sexually active
- [ ] I am sexually active at present

I partner with

- [ ] Male
- [ ] Female

I use birth control/protection

- [ ] Condom
- [ ] Pill
- [ ] Diaphragm
- [ ] IUD
- [ ] Surgical
- [ ] Spermicide
- [ ] Implant
- [ ] Rhythm
- [ ] Injection
- [ ] Sponge
- [ ] Inserts
- [ ] Abstinence

Comment ___________________________

SOCIOECONOMIC

Occupation

Employer	
Profession	

Legal

Advanced Directive	
Power of Attorney	
Living Will	

Family

Marital Status	
Spouse's/Partner's Name	
Number of Pregnancies	
Number of Miscarriages	
Number of Terminations	
Number of Children	
Children's Names and Ages	

Education

Highest Level of Education	

ACTIVITIES OF DAILY LIVING
OTHER CONCERNS

Military Service	
Blood Transfusions	
Caffeine concern	
Occupational Exposure	
Hobby Hazards	
Sleep Concern	
Stress Concern	
Weight concern	
Special Diet	
Back Care	
Exercise Description	
Bike Helmet	
Seat Belt	
Self-Exams	
Falls	