# *Blue River Family Medicine New Patient Health History*

Name_____DOB_____ Date_____

Reason for Visit_____

Preferred Pharmacy_____

Medication Allergies_____

**Current Medications**

| Name of Medication | Dose | Taken How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PAST ILLNESSES** (Please circle chronic conditions you currently have or have had)

| | | | |
|---|---|---|---|
| Allergies | Crohn's or Colitis | Heart Disease | PTSD |
| Anemia | Depression/ Anxiety | Heart Rhythm Problems | Reflux |
| Arthritis | Diabetes | High Cholesterol | Rheumatoid Disease |
| Asthma | Disc Disease/Back Pain | Hypertension | Seizures |
| Bipolar | Ear Infections | Hypothyroid | Skin Problems |
| Bladder Problems | Fibromyalgia | Insomnia | Sleep Apnea |
| Bleeding Problems | GI Bleeding | Irritable Bowel Syndrome | Stroke |
| Blood Clots | Glaucoma | Kidney Disease | Swelling |
| Cataracts | Gout | Osteoporosis | Ulcers |
| COPD | Headaches | Parkinson's Disease | |

Other_____

_____

**SURGERY HISTORY** (Please circle)

| | | | | |
|---|---|---|---|---|
| Appendectomy | Cataracts | Hernia | Knee Replacement | Tonsillectomy |
| Back Surgery | Cesarean Section | Hip Replacement | Prostate Surgery | Tubal Ligation |
| Cardiac Bypass | Gall Bladder | Hysterectomy | Thyroid Surgery | Vasectomy |

Other_____

**FAMILY HISTORY**

| | Parent | Sibling | Grandparent | Other | | Parent | Sibling | Grandparent | Other |
|---|---|---|---|---|---|---|---|---|---|
| Addiction | | | | | Diabetes | | | | |
| Asthma | | | | | Depression | | | | |
| Cancer | | | | | Heart Disease | | | | |
| -Breast | | | | | High Blood Pressure | | | | |
| -Cervical | | | | | High Cholesterol | | | | |
| -Colon | | | | | Mental Disorder | | | | |
| -Ovarian | | | | | Osteoporosis | | | | |
| -Pancreatic | | | | | Seizures | | | | |
| -Prostate | | | | | Stroke | | | | |
| -Skin | | | | | Thyroid Disease | | | | |

Other_____

# *New Patient Health History*

## SOCIAL HISTORY

**Alcohol Use:** None_____ Rarely_____ Occasional_____ Daily_____

**Tobacco Use:** YES____ NO____ FORMER____

Type: Cigarettes____ Cigars____ Chewing Tobacco____ E-Cigarette____

Packs per day: _____ Cigars per day: _____ Number of Years Used: _____

**Substance Abuse:** YES_____ NO_____ PAST_____

Type: _____

Number of Years Used: _____ Year Stopped Using: _____

**Employment:** Do you work outside the home? YES_____ NO_____

Full Time_____ Part Time_____ Retired_____ Student_____ Disabled_____

Employer: _____Position:_____

**Home/Environment:** Do you feel safe in your home? YES____ NO____

If No, Type of Abuse in Home: Physical____ Mental____ Sexual____

Do you have a safe place to go? YES____ NO____

Are you: Single_____ Married _____ Widowed _____ Divorced _____ Separated _____

**Exercise:** Do you exercise regularly? YES_____ NO_____

Type: _____ Duration: _____ Times per week: _____

**Sexually Active:** YES_____ NO_____ PREVIOUSLY_____

Condom Use? YES_____ NO_____

What do you use to prevent pregnancy? _____

Have you ever been sexually abused? YES_____ NO_____

Sexual Orientation: Heterosexual _____ Homosexual _____ Bisexual _____

Do you have a history of any STI/STD's? YES_____ NO____

If yes, please indicate:

Gonorrhea____ Chlamydia____ Herpes____ Trichamonas____ Genital Warts____ HPV____

If you are 26 or younger, are you interested in the Gardasil Vaccine (to prevent cervical cancer)?

YES_____ NO_____

## FEMALE HISTORY

Number of Pregnancies: _____

Number of Miscarriages/Abortions: _____

Number of Deliveries: _____

Number of Living Children: _____

Age(s): _____

Age of First Period: _____

Date of Last Menstrual Period: _____

Date of Last Pap Smear: _____

History of Abnormal Pap? YES___NO___ Month/Year_____

Date of Last Mammogram: _____

# *New Patient Health History*

## Review of Systems

**PLEASE CHECK ALL THAT PERTAINS CURRENTLY:**

**Mental Status:** Anxiety _____ Depression _____ Trouble Sleeping _____

**Skin:** Lesions _____ Rash_____ Itching _____ Changes in Moles _____

**Lymph nodes:** Lumps _____ Pain_____ Swelling_____

**HEENT:**

**Eye:** Glasses/contacts_____ Double Vision____

**Ears:** Hearing loss_____ Drainage_____ Ringing of the Ears_____ Pain_____

**Nose:** Runny/stuff nose_____ Bloody Nose_____

**Mouth:** Sores_____ Bleeding Gums_____ Teeth or Jaw Pain_____

**Throat:** Sore Throat_____ Change in Voice_____ Cold Symptoms_____

**Neck:** Swelling_____ Stiffness_____ Lump_____

**Breasts:** Lumps_____ Pain_____ Nipple Discharge _____ Perform Routine Breast Exam_____

**Endocrine:** Decreased Energy_____ Fatigue_____

**Respiratory:** Wheezing _____ Cough_____ Difficulty Breathing _____ Shortness of Breath_____

**Cardiovascular:** Chest Pain_____ Palpitations_____ Swelling in Legs_____

**Gastrointestinal**: Change In Appetite_____ Difficulty Swallowing_____ Nausea/Vomiting_____

Vomiting Blood_____ Blood in Stool_____ Abdominal Pain_____

Diarrhea_____Constipation_____ Hemorrhoids_____

**Genital/Urinary:** Change in Urination_____ Painful Urination_____ Blood in Urine____

Frequent Urination at Night_____ Incontinence or Loss of Urine_____ Erectile Dysfunction_____

**Musculoskeletal:** Joint pain_____ Muscle Pain_____ Arthritis_____

**Neuro:** Visual changes_____ Headaches_____ Weakness_____ Numbness_____ Seizures_____

**Additional concerns:**

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