New Patient History (age 4 and up)

Generations Family Medicine

Name:

Date:

CHILDHOOD ILLNESSES

PLEASE CIRCLE ALL THAT APPLY

Attention deficit disorder
Asthma
Prematurity (before 37 weeks)
Developmental delay
Autism
Chicken pox

OTHER: (PLEASE LIST)

MEDICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY

Nasal/Sinus Allergies
Asthma
Emphysema (COPD)
Eczema
Rheumatoid arthritis
Osteoarthritis
Deep vein blood clots
Diabetes
Hypothyroidism (low thyroid)
High blood pressure
Heart attack
Heart murmur
Congestive heart failure
High cholesterol
Alcoholism
Anxiety
Depression
Stroke
Migraine
Epilepsy
Urinary incontinance
Kidney stones
Erectile Dysfunction
Abnormal Pap smear
Uterine fibroids
Endometriosis
Ovarian Cysts
Cancer (list type: ________________)
HIV/AIDS

OTHER CONDITIONS: (PLEASE LIST)

SURGICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY

Skin biopsy
Cholecystectomy (gallbladder)
Hernia repair
Hysterectomy (uterus only)
Hysterectomy BSO (uterus and ovaries)
Spinal surgery
Breast biopsy
Appendectomy
Tubal ligation ("tubes tied")
Tonsillectomy
Tympanostomy (ear) tubes
Vasectomy
Wisdom teeth
Heart bypass
Coronary artery stent
Cesarean section

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OTHER: (PLEASE LIST)

WOMEN ONLY

Number of pregnancies	
Number of full term births	
Number of premature births (< 37 wks)	
Number of miscarriages or abortions	
Number of children born (total)	
Number of C-sections	
Childbirth complications?	

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IMMUNIZATION HISTORY

PLEASE CIRCLE ALL THAT APPLY

Tetanus (Td or TDaP)	Year: _______	don’t know
Hepatitis B (three shot series)	Year: _______	don’t know
MMR/measles	Year: _______	don’t know
Pneumonia vaccine (Pneumovax)	Year: _______	don’t know
HPV vaccine (Guardasil)	Year: _______	don’t know
Shingles (Zostavax)	Year: _______	don’t know
Tuberculosis (TB) test (PPD)	Year: _______	don’t know
Did you have chicken pox disease?	Year: _______	don't know

HEALTH MAINTENANCE

For Men:

Date of last cholesterol check: ________

Date of last PSA level:______________

Date of last colonoscopy: ___________

For Women:

Date of last Pap smear: _______________

Date of last cholesterol check: ______________

Date of last mammogram: ______________

Date of last colonoscopy: ______________

Date of last bone density scan(DEXA): _____________

Lifestyle

What is your marital status? Married Single

What is your current job or occupation?

List any exposures (toxins, tuberculosis etc)

Who else lives with you at your home?

Do you smoke cigarettes now? yes no

packs per day=

years smoking=

Did you smoke in the past? yes no

quit date

packs per day=

years smoking=

Do you drink alcohol? yes no

how many drinks per day

Did you drink more in the past? yes no

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how many drinks per day			
Do you use street drugs?	yes	no	
Did you ever use drugs in the past?	yes	no	
Have you ever injected IV drugs?	yes	no	
Do you exercise?	yes	no	What kind?
Have you ever been sexually active?	yes	no	
Are you sexually active now?	yes	no	
Do you have more than one partner?	yes	no	
Do you use condoms during sex?	yes	no	
Have you ever had an HIV test?	yes	no	Year: Results:
Have you ever been hurt or threatened by your partner?	yes	no	
Do you have an **Advance Directive for End-of-Life Care?**	yes	no	**Please give us a copy if you do.**

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FAMILY HISTORY

PLEASE CIRCLE ALL THAT APPLY

Condition							
Asthma	mother	father	brother	sister	son	daughter	other: ______
Diabetes	mother	father	brother	sister	son	daughter	other: ______
Heart Attack	mother	father	brother	sister	son	daughter	other: ______
High Cholesterol	mother	father	brother	sister	son	daughter	other: ______
Hypertension	mother	father	brother	sister	son	daughter	other: ______
Stroke	mother	father	brother	sister	son	daughter	other: ______
Depression	mother	father	brother	sister	son	daughter	other: ______
Breast Cancer	mother	father	brother	sister	son	daughter	other: ______
Colon Cancer	mother	father	brother	sister	son	daughter	other: ______
Melanoma	mother	father	brother	sister	son	daughter	other: ______
Ovarian Cancer	mother	sister	daughter	other: __________			
Prostate Cancer	father	brother	son	other: __________			
Other Cancer	mother	father	brother	sister	son	daughter	other: ______

Other Conditions (please list):

SKIN HEALTH

Please circle any concerns you have about your skin:

- lines/wrinkles
- brown spots (melasma)
- excess hair growth
- acne
- scars
- skin cancer
- other: ________________________

Do you wear sunscreen every day? YES NO

Do you wear an antioxidant product? YES NO

Would you like a free consultation with our Licensed Aesthetician regarding these problems?

YES NO

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MEDICATIONS

	Name	Dose	Number of times per day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Do you take any vitamins? yes no List:

Do you take any natural supplements? yes no List:

Allergies - Circle all that you have

Penicillin

Latex

Sulpha

OTHER: