New Patient Health History

Clayton Family Medicine
Brian Pratt, MD

Full Name: _____Birth Date: _____ Date: _____

ALLERGIES ____ NO MEDICATION ALLERGIES

MEDICATION	ALLERGIC REACTION

Do you have other allergies such as foods or bee stings? YES_____ NO _____
If so please list your other allergies:
_____

PHARMACY INFORMATION (Please list pharmacy/pharmacies you use)
Local pharmacy _____
Mail order pharmacy _____
Other _____

MEDICATIONS - Please list all you current medications, vitamins, and supplements (use additional page if needed).

MEDICATION (Please list ALL)	DOSE (mg, strength, etc.)	TIMES PER DAY (Instructions - How you take)

PLEASE REMEMBER TO BRING ALL OF YOUR MEDICATION BOTTLES TO ALL APPOINTMENTS.
NO REFILLS OR MEDICATION CHANGES CAN BE MADE WITHOUT CHECKING YOUR BOTTLES.

HEALTH MAINTENANCE SCREENING, TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N
PSA	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY – Please give date of most recent

Last Tetanus Booster or TdaP:	Last Pneumovax 23:
Last Flu Vaccine:	Last Prevnar 13:
Last Zostavax Vaccine (old Shingles):	Last Shingrix (new Shingles):
Hepatitis B:	Hepatitis C:
HPV:	

PAST MEDICAL HISTORY - Have you ever been diagnosed with any of the following conditions? Check all that apply:

	Abuse		Depression		Kidney stones		Stroke
	ADD/ADHD		Diabetes		Liver disease		Thyroid problem
	Allergies/hayfever		Diverticulitis		Lung disease		Tuberculosis
	Anemia		Ear/hearing problems		Mammogram abnormal		Varicosities
	Anxiety disorder		Eating disorder		Ménière's disease		Vision
	Arthritis		Fibromyalgia		Muscle/joint/bone		Dementia
	Asthma		GERD/acid reflux		Osteopenia		Diverticulosis
	Atrial fibrillation		GI problems		Osteoporosis		Glaucoma
	Bladder/kidney problems		Gout		Ovarian cancer		Heart murmur
	Blood clot		Chronic Headaches		PAP Smear abnormal		History of fractures
	Blood disease		Heart disease		PSA abnormal (men)		Hyperlipidemia
	COPD		History of falls		Pulmonary embolism		Chronic pain
	Cancer		Hypertension		Pulmonary/Lung nodule		Peripheral artery disease
	Chronic Constipation		Hypothyroidism		Recurrent UTI		Prostate problems
	Coronary artery disease		Kidney disease		Seizure/epilepsy		Sleep apnea
					Skin problems		

Other conditions not listed above: _____

_____

Patient name: _____ Date of Birth: _____

SURGERIES - Please list ALL surgical procedures you have had and the approximate year.

TYPE	DATE	LOCATION/FACILITY

Have you ever been hospitalized not counting the surgeries above? Y N
When? _____

OTHER PROVIDERS/SPECIALISTS - Do you see any other health care providers? Yes____ No _____

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		
Previous Primary Care		

FAMILY MEDICAL HISTORY - Please note any of the following conditions that a member of your family has been diagnosed with and mark the proper column to indicate which family members had that condition.

	Birth Mother	Birth Father	Sister	Brother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Alcoholism								
Autoimmune disease								
Blood Disease								
Cancer								
Depression/Anxiety/Bipolar								
Diabetes								
High Blood Pressure								
Heart Disease								
Kidney Disease								
Liver Disease								
Lung Disease								
Stroke								
Other:_____								
Other:_____								

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SOCIAL HISTORY – Please circle or fill in the answer in the given space

Smoking Status	NEVER FORMER CURRENT EVERYDAY OCCASSIONAL SMOKER
Average amount smoked daily?	5 cigarettes or less 1/2 pack 3/4 pack 1 pack 2 or more packs
Tobacco years of Use	_____ YEARS
Has Smoked since Age	_____
If a former smoker what year did you quit?	
Are you exposed to second hand smoke?	YES NO
Other Tobacco	YES NO PIPE CIGAR SNUFF CHEW E-CIGARETTE
Alcohol Intake	YES NO BEER WINE LIQUOR
Have you ever regularly consumed more alcohol than you drink now?	YES NO
In the past year, on how many days have you had more than 4 drinks?	
Diet	REGULAR VEGITARIAN VEGAN DIABETIC GLUTEN FREE CARDIAC CARBOHYDRATE SPECIFIC
Caffeine Intake	LOW MEDIUM HIGH
Illicit Drugs	YES NO IF YES _____

OTHER HEALTH ISSUES – Please circle or fill in the answer

Occupation	
Marital Status	SINGLE MARRIED DIVORCED SEPARATED DOMESTIC PARTNER WIDOWED
Live alone or with others	ALONE WITH OTHERS
Number of Children	_____
Advance Directive	YES NO
Exotic Pets	YES NO
Exercise Level	NONE OCCASSIONAL MODERATE HEAVY
Education	LESS THAN 8TH GRADE 9 10 11 12 2YR COLLEGE 4YR COLLEGE POST GRADUATE
Presence of domestic violence	YES NO
Sexual orientation	HETEROSEXAL HOMOSEXUAL BISEXUAL
Sexually involved currently?	YES NO
Birth Control Method	NONE CONDOM PILL/RING/PATCH/INJECTION IUD VASECTOMY
General Stress Level	LOW MEDIUM HIGH
Guns present in home	YES NO
Working smoke detector in home?	YES NO
Seat belts used routinely	YES NO
Sunscreen used routinely	YES NO
Do you feel safe at home	YES NO

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