NEW PATIENT INFORMATION (ADULT)

Name:_____ DOB:_____/_____/_____ Date:_____/_____/_____

1. Medication

List any Medications you cannot take and why:_____

List the medicines you are currently taking:

Medication (name / dose)	Medication (name / dose)	Medication (name / dose)

2. Illnesses:

Check if you have or have had any of the following illness:

	Rheumatic Fever		Pneumonia		Cancer		Tuberculosis
	Heart Trouble		Emphysema		Menstrual Problems		Glaucoma
	High Blood Pressure		Ulcers		Stroke		Colitis
	Asthma		Hepatitis		Epilepsy / Convulsions		Blood Clots
	Hay Fever		Urinary Tract Problems		Nervous or Mental Illness		Sexual Problems
	Diabetes		Venereal Disease		Skin Problems		Thyroid Problems
	Anemia		Arthritis		Other (specify)		

3. Surgeries / Hospitalizations / Injuries:

List any surgeries, Injuries or operations:

Surgery, Injury, or Reason for hospitalization	Year or Age	Hospital	Doctor's Name

4. Social Habits:

	Alcohol Consumption		Tobacco Usage	Exercise (list the exercise you do regularly)		Seat belt usage
	Never		Cigarettes			Always
	3-10 times / year		Packs/day:			Sometimes
	Once a week		Age began:			Never
	2-3 times a week		Quit/Age:			
	Daily		Never			
	Beer wine liquor (please circle)		Chew /Pipe/Cigars			

5. Preventive Health History:

Please enter the dates for the following:

Tetanus Shot?_____ Pneumonia Shot?_____ TB Test?_____ Flu Shot?_____

Mammogram?_____ Prostate Cancer Test?_____ Dexa Scan?_____ PAP?_____

Colon Cancer Test?_____ (type)_____ Cholesterol Check?_____

6. Family Medical History

Check if any of these diseases have occurred in blood relatives. List those who have had it.

	Diabetes			Epilepsy			Mental Illness	
	High Blood Pressure			Arthritis			Cancer (type?)	
	Anemia			Allergy				
	Bleeding Disorder			Asthma			Heart Trouble	
	Thyroid Disease			Stroke			Other (list)	
	Tuberculosis			Suicide				

Please list any relatives who have died and the cause of death:

Relative	Cause of Death	Age at Death

7. Personal History

List those who are living at home with you (spouse, children, parent, ect):_____

Last grade of education?_____ Occupation?_____ Spouse's Occupation?_____

Hobbies?_____ How long have you lived in Idaho?_____

8. Woman's History

Age began menstrual periods:_____ Number of pregnancies?_____ miscarriages?_____ abortions:_____

Describe your menstrual cycle:_____ Age at Menopause?_____