FAMILY MEDICINE HEALTH CENTER

New Patient History Form

Legal name: _____
Preferred name: _____
DOB: _____

Thank you for taking the time to complete this form. If you have entered any of this information into your Mychart you do not need to relist.

Please list all current health issues:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Please list all current medications with doses and frequencies (include over the counter medications and natural remedies):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Please list all Allergies:

- _____
- _____
- _____

Please list all surgeries and years in which they occurred:

- _____
- _____
- _____
- _____
- _____
- _____

Family History (check all that apply):

Relationship	Alcohol/drug use	Arthritis	Asthma	Cancer (Type?)	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Mental Illness	Stroke	Vision Issues	Other_____
Mother															
Father															
Sister															
Brother															
Daughter															
Son															
Maternal Aunt															
Paternal Aunt															
Maternal Uncle															
Paternal Uncle															
Maternal Grandmother															
Maternal Grandfather															
Paternal Grandmother															
Paternal Grandfather															
Other															

☐ I am adopted ☐ I don't know my family history

Habits:

Do you smoke? ☐Never ☐Previously ☐Current **Use smokeless tobacco or vape?** ☐ Yes ☐ No

Quit Date: _____ Pack/day: _____ Years smoked: _____

Do you drink alcohol? ☐Never ☐Previously ☐Current

How often do you drink? ☐ Less than once/mo ☐ 2-4x/mo ☐ 2-3x/week ☐ Most days

How many drinks do you have on a day you are drinking: _____

Do you use drugs? ☐Never ☐Previously ☐Current **Have you ever injected drugs?** ☐ Yes ☐ No

Type of drug(s) used:

☐Benzodiazepines ☐Ecstasy ☐Cocaine ☐Heroin ☐Marijuana ☐Methamphetamine ☐Opioids

Are you currently sexually active? ☐Yes ☐Not right now ☐Never

Are you and your partner(s) using a birth control method? ☐ Yes ☐ No

If yes, circle all that apply: Condoms Pill Patch Vaginal ring Depo injection IUD Nexplanon Spermicide Withdrawal Tubal ligation Vasectomy

What types of partners do you have: ☐Male ☐Female ☐Both

Pregnancy History: ☐This does not apply to me

How many pregnancies have you had? _____ How many deliveries? _____