Family Focused Healthcare

New Patient Form

Name: _____ DOB _____

Preferred name:_____

Please Circle: Married Divorced Separated Widowed Single

Significant Other Name:_____

Names of others in household: _____

Names of people we have permission to speak with: _____

Current Job: _____

Pharmacy _____PLEASE BRING YOUR PILL BOTTLES TO YOUR FIRST APPOINTMENT.

Allergies

Past Surgical History:

OBGYN History

Age of First period: _____ Age of Menopause: _____

Have you ever had an abnormal pap _____ If yes, date_____

Pregnancies:

Total number_____, Full term_____, Miscarriages_____, Abortions_____, Premature_____.

Family Medical History (Check all that apply)

Illness	You	Father	Mother	Sibling	Grandparent
Heart attack of heart disease					
High Cholesterol					
High Blood Pressure					
Diabetes					
Stroke					
Kidney Disease					
Liver Disease					
Bleeding/Clotting disorder					
Asthma					
Anemia					
Colon/Bowel Problems					
Glaucoma					
Thyroid disease					
Depression/Anxiety					
Seizures					
Drug Addiction					
Alcohol Addiction					
Cancer (what type?)					

Social History

Are you sexually active? YES NO Partners MEN WOMEN BOTH

Have you ever had a sexually transmitted disease? YES NO Diagnosis_____

Do you smoke? YES NO How many per day? _____

Do you use other tobacco products? _____

Have you smoked or used tobacco in the past? YES NO

Do you drink alcohol? YES NO How much?_____

Do you currently use recreational drugs?_____ What type_____

Have you ever had a drug problem (prescription or illegal) YES NO

Do you have a history of domestic abuse? YES NO

History/current Military service YES NO Type: _____

Do you have any other medical Providers? (List their names and specialty)