Family Focused Healthcare – New Patient Form

Name ______________________________ **DOB**__________ **Ph#** _______________

Address ____

Preferred Name _______________ **EMAIL**_____________________________

** Would you like to receive text/email reminders?

Yes	No

Please circle: Married Divorced Separated Widowed Single

Significant other name ______________________

Others in the household ____

Current Job ___________________________

Preferred Pharmacy __________________

Allergies:

Past Surgical History:

List Medication /Dosage

Medication	Dosage

Do you have any other medical providers? (list names & specialties)

OBGYN History:

Age of First Period _________ Age of Menopause __________

Have you ever had a abnormal pap? _______ If yes, date? _____________

Total # of pregnancies _____ Full term____ Miscarriages____ Abortions___ Premature____

Family Medical History (check all that apply)

ILLNESS	YOU	MOTHER	FATHER	SIBLING	GRAND PARENTS
Heart Disease					
High Cholesterol					
High Blood Pressure					
Diabetes					
Stroke					
Kidney Disease					
Liver Disease					
Blood/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 drink alcohol? YES NO How much? _________________________

Do you currently use recreational drugs? YES NO What type? ____________________

Do you have a history of domestic violence? YES NO

History or current Military services? YES NO Type____________________________