



Adult Health History for New Patient

Name: _____ **Birth Date:** _____ **Today's Date:** _____

Preferred Pharmacy (name and location): _____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill out all pages. If you cannot remember specific details, please provide your best guess.

Medications

Please list all prescription and non-prescription medications, vitamins, and any supplements that you take, even on a non-regular basis.

Medication	Dosage	Times per day

Allergies

Please list all allergies to medications, latex, shellfish or iodine.

Allergies	Known Side Effects or Reactions

Personal Medical History

Condition	Current	Past	Comments
Alcohol/Drug Abuse			
Allergies (Hay fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid/Osteo)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (Leg/Lung)			
Blood Transfusion			
Breast Lump (Benign)			
Cancer (Please List Type)			
Cataracts			
Chicken Pox			
Colon Polyps			
Coronary Artery Disease			
Depression			
Diabetes			
Diverticulitis			
Emphysema			
Fractures (Broken Bones)			
Gallbladder Disease			
GERD/Heartburn			
Glaucoma			
Gout			
Gynecological (Endometriosis)			
Gynecological (Fibroids)			
Gynecological (Other)			
Heart Attack			
Hepatitis (A, B or C)			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (Enlargement/Nodules)			
Seizure/Epilepsy			
Skin Conditions			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid Disease			
Other:			
Other:			
Other:			

Health Maintenance Screening Tests

For Females:	Mammogram	Date: _____	Normal / Abnormal
	Pap Smear	Date: _____	Normal / Abnormal
	Bone Density	Date: _____	Normal / Abnormal
	Lipid Panel (Cholesterol)	Date: _____	Normal / Abnormal
For Males:	Testicular Exam	Date: _____	Normal / Abnormal
	Prostate Exam	Date: _____	Normal / Abnormal
	Lipid Panel (Cholesterol)	Date: _____	Normal / Abnormal

Surgical History

Procedure	Yes	Year	Comments
Abdominal Surgery			
Angioplasty (with or without stent)			
Appendectomy (Appendix Removal)			
Back Surgery			
Biopsy (Location)			
Breast Surgery/Biopsy			Circle: Right / Left / Both
Carpal Tunnel			Circle: Right / Left / Both
Colonoscopy			
Colostomy			
Coronary Bypass			
Coronary Stent			
EGD (Stomach Endoscopy)			
Cataract			
Gallbladder Removal			Laparoscopic? Yes / No
Gastric Bypass			
Heart Surgery (Other than Coronary Bypass)			
Hernia Repair			
Hip Surgery			Circle: Right / Left / Both
Hysterectomy (Total, including ovaries)			Circle: Laparoscopic / Vaginal / Abdominal
Hysterectomy (Partial, ovaries left)			Circle: Laparoscopic / Vaginal / Abdominal
Knee Surgery			Circle: Right / Left / Both
LASIX			
LEEP (Cervix Surgery)			
Neck Surgery			
Ovary Removal			Circle: Right / Left / Both
Pacemaker			
Sigmoidoscopy			
Sinus Surgery			
Small Bowel Resection			
Thyroidectomy			
Tubal Ligation			
Vasectomy			
Other:			
Other:			
Other:			

Family History

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative:	Comments
No Significant History Known										
ADD/ADHD										
Alcoholism/Drug Abuse										
Allergies										
Alzheimer's										
Anxiety										
Asthma										
Arthritis										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Blood Disease (Please List)										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Prostate										
Cancer, Other										
Colon Polyps										
COPD/Emphysema										
Coronary Artery Disease										
Depression										
Developmental Delay										
Diabetes										
Genetic Disorders (Explain)										
Glaucoma										
Heart Disease										
Hearing Disease										
Hepatitis B or C										
High Blood Pressure										
High Cholesterol										
Hip Fracture										
Kidney Disease										
Kidney Stones										
Learning Disabilities										
Migraine Headaches										
Mental Illness										
Obesity										
Osteoporosis										
Seizure Disorder										
Skin Conditions (Please List)										
Stroke										
Thyroid Disease										
Other:										
Other:										
Other:										

Health Issues

Tobacco Use:

Smoke Cigarettes? Never Former Yes
Current Smoker: Packs/day: _____ Number of years: _____
Former smoker: Quit date: _____ How many years did you smoke? _____
Approximately how many packs per day did you smoke? _____
Other Tobacco: Pipe Cigar Snuff Chew

Alcohol Use:

Do you drink alcohol? No Yes
Number of drinks/week: _____
Type: Beer Wine Liquor

Caffeine Use:

Do you use caffeine? No Yes
Number of drinks/day: _____
Type: Chocolate Coffee/Tea Energy Drinks Soda

Drug Use:

Do you use marijuana or recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

Sexual Activity:

Sexually involved currently? No Yes
Sexual partner(s) is/are/have been: Male Female
History of STDs: No Yes, type: _____
Birth control method: None Needed Condom Pill Diaphragm Vasectomy
 Other: _____

Social History

Occupation (or prior occupation): _____ Employer: _____
Highest level of education: _____
Marital status: Single Partner Married Divorced Widowed
Spouse/partner name: _____ Number of children: _____

Women's Health History

Total number of pregnancies: _____ Number of births: _____
Age at beginning of periods (menstruation): _____
Age at end of periods (menopause/hysterectomy): _____ Not applicable
Date (month/date if known) of last menstrual period: _____ How long do they last? _____ days

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (HIPAA)
Family Physicians of Greeley, PLLP

Name: _____
Name of Patient or Guardian

Date of Birth: _____

Release of Information

I authorize Family Physicians of Greeley, its employees and agents to disclose my health information, including my visit records, diagnoses, treatments and test results, to the person(s) identified below. I understand that any personal health information released to the person(s) identified may be subject to re-disclosure by such person and may no longer be protected by applicable federal and state privacy laws.

This information may be released to:

Spouse: _____

Child[ren]: _____

Other: _____

This **Release of Information** will remain in effect until terminated by me in writing.

I understand that I have a right to revoke this authorization by providing written notice to Family Physicians of Greeley. However, this authorization may not be revoked if Family Physicians of Greeley, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for healthcare services.

Messages

Please call: my home: _____ my work: _____

my cell phone: _____ other: _____

If unable to reach me: you may leave a detailed message

please leave a message asking me to return your call

other: _____

The best time to reach me is (*days*) _____, between (*time*) _____

Signed: _____

Date: _____

Witness: _____

Date: _____