New Patient Medical History & Annual Health Assessment



Please answer each section. Write "none", "unknown" or "not applicable" if needed.
You may choose to discuss sensitive information privately with your care team.

Patient name: _____ **Date of birth:** _____ **Date:** _____

Reason for today's visit

- ☐ New patient
- ☐ Illness
- ☐ Pre-surgical clearance
- ☐ Hospital discharge follow-up
- ☐ Work injury
- ☐ Auto accident
- ☐ Hormone replacement
- ☐ Medically supervised weight loss program

Preferred pharmacy: _____ Phone: _____

Pharmacy address: _____

Mail order pharmacy: _____

Current / previous primary care provider(s)

Name: _____ Phone: _____

Name: _____ Phone: _____

Current / previous specialists

Cardiologist: _____ Phone: _____

Dermatologist: _____ Phone: _____

Gastroenterologist: _____ Phone: _____

Ophthalmologist: _____ Phone: _____

Other, please specify: _____ Phone: _____

Other, please specify: _____ Phone: _____

Any current concerns?

_____

Allergies and sensitivities to medications, food, animals or other. Please include the reactions:

_____

_____

☐ No known allergies

Patient Medical History

Current medications

List ALL current prescription and non-prescription medications, contraceptives, vitamins and supplements.

Medication name	Frequency	As of	Prescriber

☐ Not taking medications

Past medical history

Have you ever had any of these conditions? Check Yes or No for each.

Past medical history	Yes	No	Past medical history	Yes	No
Anemia	☐	☐	HIV / AIDS / hepatitis	☐	☐
Asthma	☐	☐	Low / high thyroid function	☐	☐
Blood clot / DVT	☐	☐	Lyme disease	☐	☐
Cancer	☐	☐	Osteoporosis / osteopenia	☐	☐
COPD	☐	☐	Peripheral vascular disease	☐	☐
Diabetes (type 1 or type 2)	☐	☐	Psoriasis	☐	☐
Gout	☐	☐	Kidney failure / kidney disease	☐	☐
Heart attack / angina	☐	☐	Rheumatoid arthritis / lupus	☐	☐
Heart disease / pacemaker	☐	☐	Stroke	☐	☐
High blood pressure	☐	☐	Tuberculosis	☐	☐
History of blood transfusion	☐	☐	Ulcer / acid reflux / GERD	☐	☐
History of prednisone / steroid use	☐	☐	Other (please specify below)	☐	☐

Please specify cancer type, diabetes type or other conditions (include dates, if known):

Patient Medical History

Past surgeries

Surgery / procedure	Reason	Surgeon	Date

Past hospitalizations

Hospital	Reason	Date

Family history

Relationship	Living or deceased?	Inherited diseases, chronic illness / cause of death
Mother		
Father		
Paternal grandfather		
Paternal grandmother		
Maternal grandfather		
Maternal grandmother		
Brothers		
Sisters		
Sons		
Daughters		

Patient Medical History

Preventive care

Please list the date of your most recent visit, test or vaccination. If unknown, check "Unknown."

Visit / test / vaccination	Date	Unknown	Visit / test / vaccination	Date	Unknown
Complete physical		☐	Pneumovax 23		☐
Colonoscopy		☐	Shingles		☐
Dental cleaning		☐	HPV		☐
Eye exam		☐	Meningitis		☐
COVID vaccine		☐	TDAP		☐
COVID booster		☐	Influenza vaccination		☐
Tuberculosis test		☐	Measles immunization		☐
Tetanus immunization		☐	Hepatitis A immunization		☐
Prevnar 13		☐	Hepatitis B immunization		☐

Oral/dental care and other health behaviors

Describe your oral/dental care and any concerns or difficulty getting dental care.

Describe any regular smoke exposure, sexual health concerns (if relevant) or other health-related risks.

For females only

Last menstrual period: _____ Length of period: _____

Form of birth control: _____

Last Pap smear: _____

Provider: _____ Phone: _____

Last mammogram: _____

Ordering provider: _____ Phone: _____

Are you experiencing or actively in menopause? ☐ Yes ☐ No

Last pregnancy: _____

Have you ever had any miscarriages? ☐ Yes ☐ No If yes, how many: _____

Live births? ☐ Yes ☐ No If yes, how many: _____

Terminations? ☐ Yes ☐ No If yes, how many: _____

Patient Medical History

Social history and lifestyle

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What do you consider your stress level is? ☐ Low ☐ Medium ☐ High

Travel outside the U.S. within the past three years? ☐ Yes ☐ No

Where and when?

Is your time well balanced between your jobs, family and hobbies? ☐ Yes ☐ No

Do you wear seat belts?

☐ Always ☐ Usually ☐ Occasionally ☐ Never

If you ride a bicycle or motorcycle, do you wear a bike helmet? ☐ Yes ☐ No

Do you have frequent falls? ☐ Yes ☐ No

If there is a gun in your home, is it out of children's reach and unloaded? ☐ Yes ☐ No

If you are a female, do you do a monthly self-breast exam? ☐ Yes ☐ No

If you are a male, do you do a monthly self-testicular exam? ☐ Yes ☐ No

Do you practice "safe sex"? ☐ Yes ☐ No

Have you used illegal drugs? ☐ Yes ☐ No

How would you describe your dietary intake?

How many cups of coffee or caffeinated drinks do you drink daily?

What (if any) physical activity/exercise do you engage in and how often?

Do you smoke? ☐ Now ☐ Past ☐ Never

If so, how many per day and for how long?

Alcohol: amount per day: Amount per week:

How many times in the past month have you had more than 4 alcoholic drinks in one day?

Annual Comprehensive Health Assessment

B. Mental health / substance use - patient and family

Are you currently experiencing any of the following? Please check all that apply:

- ☐ Loss of interest in things you used to enjoy
- ☐ Chronic sadness
- ☐ Problems concentrating/decision making
- ☐ Restlessness, inability to sit still
- ☐ Hopelessness
- ☐ Thoughts of death/suicide
- ☐ Feelings of worthlessness, guilt
- ☐ Loss of energy/exhaustion
- ☐ Changes in appetite
- ☐ Other, please specify below

Other, please specify: _____

Describe any past mental health or alcohol/drug use concerns, including treatment or counseling.

Describe any family history of mental health or alcohol/drug use concerns. Include the relationship.

C. Family, social and cultural characteristics

Who lives with you, and who can you turn to for support?

What preferences, strengths, concerns or social/cultural factors should we consider in your care?

D. Communication needs

Do you have difficulty hearing, seeing, remembering, thinking clearly, or understanding information? Please describe.

What assistance or accommodations would help you during your visits? Examples: large-print materials, written instructions, help with hearing, or a support person.