NEW PATIENT HISTORY RECORD

Name _____ Birthdate _____

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

1. LANGUAGE:

□English □Spanish □Other_____ □**Decline to Specify**

2. ETHNICITY:

□Not Hispanic/Latino □Hispanic/Latino → ***If Hispanic/Latino please specify:***
□Mexican, Mexican American, Chicano/a
□Puerto Rican □Cuban □Other _____

□**Decline to Specify**

3. RACE:

□White □American Indian/Alaska Native □Asian □Other____
□Black/African American □Native Hawaiian/Other Pacific Islander □**Decline to Specify**

4. GENDER IDENTITY:

□Male □Transgender Male (Female-to-Male) □Transgender Female (Male-to-Female) □Other_____
□Female □Neither Male or Female □**Decline to Specify**

5. MARITAL STATUS:

□Married □Domestic Partner □Annulled □Widowed
□Divorced □Legally Separated □Never Married □**Decline to Specify**

6. EMPLOYMENT STATUS:

□Full Time □Retired □Self-Employed □**Decline to Specify**
□Part Time □Not Employed □Active Military **(Unknown)**

7. HIGHEST LEVEL OF EDUCATION:

□Less than High School □High School □Associate's Degree □Doctorate
□Some High school □Vocational Degree □Bachelor's Degree □**Decline to Specify**
□Some College □Master's Degree

8. LIVE WITH (check all that apply):

□Alone □Child/Children □Step-Parent □Cousin(s)
□Spouse □Mother(s) □Sibling(s) □**Decline to Specify**
□Significant Other □Father(s) □Grandparent(s)
□Roommate(s) □Guardian □Aunt(s)/Uncle(s)

Name _____ Birthdate _____

MEDICINES YOU ARE TAKING List medicines and dosages, birth control pills, or vitamins you take with or without a prescription. Please bring your current medication containers along with you for your appointment.

_____
_____
_____
_____
_____
_____

DRUG and/or OTHER ALLERGIES List those to which you are allergic.

_____
_____
_____
_____

HOSPITALIZATIONS List serious illnesses and injuries or operations and approximate year. EXCLUDE NORMAL PREGNANCIES.

Year	Serious illness, injury or operation	Name of hospital	City and State
____	_____	_____	
____	_____	_____	
____	_____	_____	
____	_____	_____	
____	_____	_____	

IMMUNIZATIONS Check those that you have had. Note most recent year received.

□ Pneumonia _____ □ Polio _____ □ Flu _____ □ Tetanus _____
□ Rubella _____ □ Others _____ ____ _____ _____
_____ ____ _____ _____

YOUR FAMILY'S HEALTH

	First Name	Year of Birth	Health is: Good	Poor	Died at Age:	Cause of Death
Father	_____	_____	□	□	□_____	_____
Mother	_____	_____	□	□	□_____	_____
Brothers	_____	_____	□	□	□_____	_____
&	_____	_____	□	□	□_____	_____
Sisters	_____	_____	□	□	□_____	_____
	_____	_____	□	□	□_____	_____
	_____	_____	□	□	□_____	_____
Spouse	_____	_____	□	□	□_____	_____
Children	_____	_____	□	□	□_____	_____
	_____	_____	□	□	□_____	_____
	_____	_____	□	□	□_____	_____
	_____	_____	□	□	□_____	_____
	_____	_____	□	□	□_____	_____

Your name _____ Birthdate _____

ILLNESSES Check where you or members of your family have had the following illnesses or problems

You	Your family	
□	□	Alcoholism
□	□	Anemia
□	□	Asthma
□	□	Cancer, tumor
□	□	Diabetes
□	□	Drug abuse
□	□	Depression
□	□	Eczema, hives, rashes
□	□	Eye problems
□	□	Glaucoma
□	□	Heart disease
□	□	High blood pressure
□	□	HIV
□	□	Kidney/bladder problems
□	□	Liver disease, hepatitis, yellow, jaundice
□	□	Lung disease, tuberculosis
□	□	Mumps, measles, chicken pox
□	□	Nervous breakdown/mental illness
□	□	Phlebitis
□	□	Rheumatic fever
□	□	Rubella, German measles
□	□	Sexually transmitted disease
□	□	Stroke
□	□	Suicide attempt
□	□	Thyroid disease
□	□	Ulcer in stomach/duodenum
□	□	Uncontrolled bleeding
		Other illnesses:
□	□	_____
□	□	_____

PREGNANCY HISTORY

Enter the number of:

Times pregnant …… _____

Premature births …… _____

Miscarriages ……. _____

Abortions ……. _____

Live births ……. _____

Living children ……. _____

TOBACCO USE:

Smoke Current/Former/Never

_____packs _____years

Date Quit_____

Chew Current/Former/Never

Vape Current/Former/Never

ALCOHOL USE:

□ Yes Amount per week_____

□ No

Ever abuse alcohol? Y / N

DRUG USE:

□ Yes

□ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status.

_____ _____

Patient's/Parent/Guardian signature Date