**NEW PATIENT HISTORY RECORD**

Your 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. GENDER IDENTITY:**

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

**2. RACE:**

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

**3. ETHNICITY:**

□Not Hispanic/Latino
□Hispanic/Latino
□Decline to Specify

***If Hispanic/Latino please specify:*** □Mexican, Mexican American, Chicano/a □Puerto Rican □Cuban □Other_____

**4. LANGUAGE:**

□English
□Spanish
□Other_____
□Decline to Specify

**5. MARITAL STATUS:**

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

**6. EMPLOYMENT STATUS:**

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

**7. HIGHEST LEVEL OF EDUCATION:**

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

**8. LIVE WITH:**

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

OFFICE STAFF ONLY

Initial once 1-6 have been entered into patient demographics_____

Place in bin to be scanned

**NEW PATIENT HISTORY RECORD**

Your 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** | _____ | _____ | □ | □ | □_____ | _____ |
| | _____ | _____ | □ | □ | □_____ | _____ |
| | _____ | _____ | □ | □ | □_____ | _____ |
| | _____ | _____ | □ | □ | □_____ | _____ |
| | _____ | _____ | □ | □ | □_____ | _____ |

**NEW PATIENT HISTORY RECORD**

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