New Patient Form

Demographic Information	
Full Name:	**Date of Birth:**
Preferred Name:	**Pronouns:**
Gender at Birth:	**Gender Identity:**
Primary Care Provider:	**Occupation:**
Who lives in your household? (names, ages, relationship to you)	
What concerns or goals would you like to address in today's visit?	

What other healthcare providers do you see for your care? (□ check if you have none)	
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

Medications Please list all supplements and medications you take (□ check if you have none)		
Name of Medication	Dosage	When and how often do you take it?

Do you use any medical equipment (Ex: cane, hearing aid, cpap, home oxygen, etc.)?
□ No □ Yes, I use:

Allergies to Medications (□ check if you have none)	
Medication	Reaction

Have you ever been diagnosed or treated for any of the following? (☐ check if you have none)			
BRAIN/NERVES ☐ Anxiety ☐ Dementia ☐ Depression ☐ Migraines ☐ Multiple Sclerosis ☐ Neuropathy ☐ Seizure Disorder ☐ Stroke **LUNGS** ☐ Asthma ☐ COPD/ Emphysema ☐ Sleep Apnea ☐ Pneumonia	**CARDIOVASCULAR** ☐ Atrial Fibrillation ☐ Heart Attack/Disease ☐ Heart Failure ☐ High Blood Pressure ☐ High Cholesterol ☐ Peripheral Vascular Disease **DIGESTIVE** ☐ Acid Reflux ☐ Crohn's Disease ☐ Diverticulitis ☐ Liver Disease ☐ Ulcerative Colitis	**ENDOCRINE** ☐ Diabetes ☐ Osteoporosis ☐ Thyroid Disorder **INFECTIONS** ☐ COVID-19 ☐ HIV/AIDS **IMMUNE SYSTEM** ☐ Hay fever/ Allergies **HEMATOLOGY** ☐ Cancer:_________ ☐ Organ Transplant ☐ Bleeding disorder	**MUSCULOSKELETAL** ☐ Amputations ☐ Arthritis (osteo) ☐ Chronic Back Pain ☐ Rheumatoid Arthritis **URINARY** ☐ Chronic Kidney Disease ☐ Enlarged Prostate ☐ Erectile Dysfunction ☐ Urinary Incontinence **OTHER** ☐ ___________________ ☐ ___________________ ☐ ___________________ ☐ ___________________

Surgeries and Hospitalizations (☐ check if you have none)	
Year	Surgery or hospitalization reason

Family History – Please list all medical problems in your family, including cause of death if appropriate	
☐ I don't have a family history to share ☐ Adopted	**No Family history of:** ☐Diabetes ☐Heart Disease ☐Colon Cancer ☐Breast Cancer ☐Ovarian Cancer
Mother:	
Father:	
Sibling:	
Sibling:	
Other family members:	

Health Screenings (□ check box if done, approximate date ok)			
SCREENING TEST	**DATE**	**SCREENING TEST**	**DATE**
Dental Exam	□	Colon Cancer Screening	
Dilated Eye Exam	□	FIT/stool test	□
HIV Screening	□	Colonoscopy	□
Hepatitis C Screening	□	Prostate Test (PSA)	□
Immunizations (□ check box if done, approximate date ok)			
VACCINE	**DATE**	**VACCINE**	**DATE**
Flu	□	COVID – Moderna, Pfizer, J&J	
Tetanus	□	First	□
Pneumonia (PCV or PPV)	□	Second	□
Shingles	□	Booster	□
Reproductive Health (□ check box if done, approximate date ok)			
SCREENING TEST	**DATE**	**PREGNANCY/MENOPAUSE INFO**	
Last Pap Smear	□	Age of menopause	
Abnormal Pap Smear (if any)	□	**Any bleeding since menopause**	□ Yes □ No
Mammogram	□	# of Pregnancies	
DEXA/Bone Density Scan	□		

Patient Signature: ___________________________________ Today's Date: _______________