New Patient History - Optimum Health Family Practice
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Name _____DOB _____ Age_____Date_____

Occupation:_____

1. Please list all **medications** taken regularly, dosage, and length of time each has been used. Include over-the-counter medications, vitamins, aspirin, birth control pills, antacids, nasal sprays, eye drops, injections, and skin medications. Use additional sheet if necessary:

Medication/Dosage	**Frequency**	**Years/months taken**

2. Have you had any of the following? (please circle)
Diabetes, heart disease, cancer, emphysema, bronchitis, tuberculosis, migraine, gout, colon polyps or disease, stroke, kidney disease, gallbladder disease, high blood pressure, vascular disease, neurological disease, serious infection

3. Please list all past operations, hospitalizations, broken bones, serious illnesses, and allergies:

	Year	**Reason or Problem**
Hospitalizations and surgeries		
Other illnesses or problems		
Drug allergies or reactions (include med. name)		

*Do you see any other doctors or specialist?_____

4. **Vaccinations and childhood diseases:**
Please list approximate year of last vaccination or year of illness for the following – if known:
Td/Tdap: _____ Pneumovax (pneumonia vaccine): _____
Flu vaccine: _____ Zostavax (shingles vaccine):_____

6. **Screening tests:** If you've had any of the following tests, please note the year last performed (if known):

Lipids (cholesterol): _____ Urinalysis: _____ Glucose:_____ PSA:_____
Stools for blood:_____ Colonoscopy: _____ Mammogram: _____ EKG:_____
Pap smear: _____ Treadmill EKG: _____Bone mineral density: _____

7. What else should we know about you?_____

8. Family medical history: Not Adopted / Adopted (if adopted skip family history section)

Is there any family history of (please circle): *Ulcers, tuberculosis, alcoholism, heart disease, cancer, stroke, diabetes, emphysema, high blood pressure, high cholesterol, kidney disease, colon polyps, colon cancer, Alzheimer's disease, congenital disorders, or other serious illness.*

	Living?	**Age(s) now or age at death**	**Significant medical problems and/or cause of death**
Father	___Yes ___No	_____	_____
Mother	___Yes ___No	_____	_____
Spouse	___Yes ___No	_____	_____
Brothers	___Yes ___No	_____	_____
Sisters	___Yes ___No	_____	_____
Sons	___Yes ___No	_____	_____
Daughters	___Yes ___No	_____	_____
Grandparents			
Maternal GF	___Yes ___No	_____	_____
Maternal GM	___Yes ___No	_____	_____
Paternal GF	___Yes ___No	_____	_____
Paternal GM	___Yes ___No	_____	_____

Uncles and aunts with significant diseases:

_____

_____

___ Yes ___ No Have you ever smoked? If yes, total years you have smoked? _____

___ Yes ___ No Do you smoke now? If yes, number of cigarettes a day? _____ Packs a day? _____
Number of cigars a day? _____ Ounces of pouches a week (pipe)? _____

___ Yes ___ No Do you chew tobacco or use snuff? If yes, how much? _____
If you have quit tobacco (chewing or smoking), what year did you quit? _____

___ Yes ___ No Do you drink alcohol? If yes, how many ounces do you drink per day or week of:
Liquor? _____ oz/day or week; Wine? _____ oz/day or week; Beer? _____oz/day or week
If you have quit drinking alcohol, when did you quit? _____
Have you ever been counseled for alcohol or drug abuse? _____ Yes _____ No

___ Yes ___ No Do you or have you in the past regularly used marijuana, cocaine, amphetamines, or any other mind-altering drugs?
Please specify: _____

___ Yes ___ No Do you have a regular exercise program? If yes, how often do you exercise per week? _____
How many minutes do you exercise per session on average? _____

___ Yes ___ No Do you get exercise at work? Please describe any regular exercise: _____

___ Yes ___ No Do you wear **seat belts** in the car? _____always _____sometimes _____never Airbags in the vehicle? ___

___ Yes ___ No Do you floss your teeth regularly? When was your last dental exam? _____

___ Yes ___ No Have you ever had any **exposure to known toxins**, cancer-causing substances (carcinogens), or known hazardous materials? If yes, list materials _____

___ Yes ___ No Do you participate in any **dangerous hobbies** or activities?

Occupational history: Please list all jobs you have held in adult life and number of years worked:

_____

_____

_____

___ Yes ___ No Do you have **smoke alarms** in your home?

___ Yes ___ No Do you have risk factors for hepatitis or HIV? (i.e. multi-sexual partners, tattoos, drug use with needles, work exposure to blood, other).

What is your **current level of motivation** to maintain and improve your health? High Medium Low (circle)

What is your **worst habit** affecting your health? _____

Reviewed by:_____