NEW PATIENT HISTORY FORM

Last Name____________, First Name________ Date of Birth ________
Preferred Name___________________ Preferred Pronouns_________________________
Pharmacy name/number and cross streets_____________________________________
Do you also use a Mail Order Pharmacy? Which one?__________________________
Present Medical Concerns - Please provide a brief description of your concerns.
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Current Medications- Please include both prescription and non prescription vitamins, herbs, marijuana etc. Including dosages and how many times a day you take them.

Drug Allergies and Reactions

Personal Medical History- Please indicate whether you have had any of the following problems including date of diagnosis.

Heart Disease	Thyroid problem	Blood Clots
Myocardial Infarction/Heart Attack	Lung disease/Asthma/COPD	Diabetes type I Diabetes type II
Seizures	Depression/Anxiety	Acid Reflux
High Cholesterol	Stroke	STD/STI
High Blood Pressure	Bladder problems	Other problems please list
Liver Disease	Allergies	
Kidney Disease	Osteoporosis	
Migraine Headaches	Autoimmune Disorder	
Sleep Apnea	Heart Murmur	

Surgical History/Orthopedic History- Indicate operations and approximate date.

FAMILY CARE SOUTHWEST, P.C.

Family History- Indicate if any of these relate to any of your direct family members

Diabetes	High Blood Pressure
High Cholesterol	Autoimmune disorder
Heart Problems	Stroke
Kidney Problems	Thyroid Disorders
Depression/Mood Issues	Other
Cancer	

Social History

Occupation	Nicotine Use/ Cigarette/Pipe/Cigar/Chew/Vape
Education	_Never _Quit Date____________
Hand Dominance	_Current smoker Packs Per day____#years____
Gender Identity	_ Interested in quitting
Relationship status Partner's name	Marijuana use y/n Other recreational drugs?________
Are you sexually active Y/N With M/F/other Birth Control Method	Alcohol Use? Y/N Type of drink Frequency _______Day ________Month
Do you feel safe in your current relationship? Y/N	Caffeine use
Children	How often do you exercise? What do you do for Exercise?

Who lives in your home with you?

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Preventative Care - If applicable, Please list the approximate month/year of your last tests

Last Complete Physical Exam	Bone Density (female over 60)	Prostate Exam/PSA
Pap Smear	Mammogram	Colonoscopy
Eye Exam	Routine Bloodwork	Advanced Care Planning
Other Doctors you see		

Name ________________ Date of Birth _____________