Essential Health & Wellness

New Patient Health History Form

First name: _____ Last name: _____

Today's date: _____ Date of birth: _____

List any concerns you want to talk about during your visit: _____

Health history:	
Do you have diabetes? ☐ Yes ☐ No High blood pressure? ☐ Yes ☐ No High cholesterol? ☐ Yes ☐ No	Do you have other health conditions? _____ _____
Social history:	
Do you smoke cigarettes?	☐ Never ☐ Yes _____ # packs/day ☐ Quit Date quit _____ Years smoked _____
Do you vape (e-cigarettes)?	☐ No ☐ Yes
Do you drink alcohol?	☐ Never ☐ Yes _____ # drinks per week
Do you use recreational drugs?	☐ Never ☐ Rarely _____# times per month ☐ Marijuana ☐ Cocaine ☐ Opioids ☐ Other_____
What is your highest level of education completed?	☐ High School ☐ Trade school ☐ College ☐ Post-graduate degree(s)
Are you employed?	☐ No ☐ Retired ☐ Yes Type of work_____
Do you exercise?	☐ No ☐ Yes Type _____ How often _____ How long per activity_____
What is your marital status?	☐ Married ☐ Partnership ☐ Divorced ☐ Separated ☐ Single ☐ Widow/er
Are you sexually active?	☐ No ☐ Yes # of sexual partners _____ ☐ Men ☐ Women ☐ Both Contraception: ☐ No ☐ Yes If yes, method _____
Do you have children?	☐ No ☐ Yes # of children _____ ages _____
Surgical history/recent hospitalizations: Date and type of surgery/procedure	

First name: _____ Last name: _____ Date of birth: _____

Family history:		
Relation	**Health conditions**	**Family history of cancer?**
Mother		If yes, list relative and type of cancer.
Father		
Children		
Brother/Sister		

Preventive care:			
Recent Vaccinations:	☐ Flu	Date:	Place:
	☐ Shingles	Date:	Place:
	☐ Pneumonia	Date:	Place:
	☐ Tetanus	Date:	Place:
	☐ Other	Date:	Place:
Recent tests or procedures:	☐ Colonoscopy	Date:	Place:
	☐ Cologuard/Stool card	Date:	Place:
	☐ Mammogram	Date:	Place:
	☐ PAP	Date:	Place:
Other:			

Specialists:		
Provider's first and last name	**Specialty**	**Location**

Allergies:	**Type/Reaction:**

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Symptoms: Please check any symptoms you have now or have had in the past month.

General	Heart/circulation	Musculoskeletal	Nervous System
☐ Fever ☐ Chills ☐ Feeling poorly ☐ Feeling tired ☐ Weight gain ☐ Weight loss	☐ Chest pain ☐ Heart pounding ☐ Fast pulse ☐ Slow pulse ☐ Leg pain with exercise ☐ Leg swelling	☐ Joint pain ☐ Neck pain ☐ Joint swelling ☐ Joint stiffness ☐ Muscle aches ☐ Back pain	☐ Numbness ☐ Weakness ☐ Dizziness ☐ Fainting ☐ Confusion ☐ Headache
Eyes	**Ear/nose/throat**	**Skin**	**Reproductive**
☐ Eye pain ☐ Red eyes ☐ Eyesight problems ☐ Discharge from eyes ☐ Dry eyes ☐ Itchy eyes	☐ Earache ☐ Loss of hearing ☐ Nosebleeds ☐ Runny nose ☐ Sore throat ☐ Hoarseness	☐ Sores ☐ Rash ☐ Itching ☐ Change in a mole ☐ Unusual growth/spot	☐ Erection problems ☐ Lump in testicle ☐ Discharge from penis ☐ Breast lump ☐ Nipple discharge ☐ Abnormal Pap smear ☐ Irregular bleeding ☐ Bad cramps ☐ Pelvic pain ☐ Pain during sex ☐ Vaginal discharge Last period _____ Last Pap smear _____ Mammogram _____ Are you pregnant? ____ # of pregnancies _____ # of babies delivered ___ # of miscarriages/ abortions _____
Breathing	**Gastrointestinal**	**Psychiatric**	
☐ Coughing ☐ Wheezing ☐ Shortness of breath ☐ Trouble breathing during exercise ☐ Trouble breathing while lying down ☐ Snoring	☐ Stomach pain ☐ Upset stomach/ vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Blood in stool	☐ Thoughts of harm to self or others ☐ Sleep problems ☐ Anxiety ☐ Depression ☐ Change in personality ☐ Emotional problems	
Blood	**Endocrine**	**Genital and urinary**	
☐ Bleed easily ☐ Bruise easily ☐ Swollen glands in neck	☐ Hot flashes ☐ Muscle weakness ☐ Voice changes ☐ General weakness	☐ Pain when urinating ☐ Abnormal urination ☐ Urinate often at night ☐ Genital sores	

List other symptoms:

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