North End Waterfront Health New Patient Form

Name: ____ Age: ____________
What is your email address? ____
Where were you receiving your health care previously? __________________________
What pharmacy do you use? (Name and location/zip code) ________________________

What are your concerns/reasons for visit today? (Not all may be able to be covered today)
____
____

Personal and Family Medical History

	Living? Yes/No	Age: (or age at death)	Please list all medical issues: (include cancers, diabetes, heart issues, heart attacks, strokes, high blood pressure, high cholesterol, thyroid issues, kidney disease, alcoholism, mental illness, neurological disease etc)
Self	--------		
Mother			
Father			
Sibling 1			
Sibling 2			
Sibling 3			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Please list any surgeries or hospitalizations you have had, including dates and locations:

Surgery/Reason for hospitalization	Dates	Location

Medications and Allergies

Please list all allergies to medications and foods, as well the reaction:

Medication	Reaction

Please list all medications you take regularly (including over the counter and herbal):

Medication	Dose	Frequency

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Health Maintenance

Date of last physical exam: ________________________________
Date of last cholesterol test (and results): ________________________________
Date of colonoscopy (if applicable): ___________ Was this normal? Yes__ No__
Are you interested in sexually transmitted disease testing today? Yes__ No__

Vaccine dates (if applicable, and if known):

Tetanus	Flu	HPV (Gardasil)	Pneumonia	Zoster (Shingles)	Other

For women only:
Last menstrual period: ___________ Last Pap date: ___________
History of abnormal Pap? Yes__ No__ If yes, details: ____________________
____
What are you doing for birth control? ________________________________
Would you like to discuss birth control? Yes__ No__
If age 40+, date of last mammogram: ____________Was this normal? Yes__ No__
Have you ever been pregnant? Yes__ No__ If yes:

Number of pregnancies	Children born at term	Children born pre-term	Abortions/ Miscarriages	Living Children

Health Habits

Are you currently or have you ever been a smoker? Yes__ No__
If yes: Age you started: ____ Cigarettes/day: _____ If you quit, at what age: ___
Do you drink alcohol? Yes__ No__ If no, have you in the past? Yes__ No__
If yes, number of drinks per week: _______
Do you use any other drugs? Yes__ No__ If yes, what/amount? _______
Have you used other drugs in the past? Yes__ No__ If yes, what/amount? _______
What do you do for exercise? How often? ________________________________
Do you:

Wear seatbelts?	Yes__ No__	Have concerns for your safety at home?	Yes__ No__
Wear sunscreen?	Yes__ No__	Felt threatened by others?	Yes__ No__
Do self breast exams? (women)	Yes__ No__	Do self testicular exams? (men)	Yes__ No__
See a dentist regularly?	Yes__ No__	Have regular eye exams?	Yes__ No__

Social History

Who lives at home with you? ________________________________
Where were you born? ________________________________
What is your occupation? ________________________________
Are you (check one): Married___ Single____ Divorced____ Separated____ Partnered____
Do you have children? Yes___ No___If yes, list ages: ______________________