New Patient Information

WASHINGTON HEALTH SYSTEM
Family Medicine - North Main

Name____DOB _____ / _____ / ______
Address_____________________ City _______________ State ______ Zip ______
Circle Payment Type: Insurance / Self Pay
Emergency Contact___________________Phone__________Relationship________

If Patient is a Minor
Mother's full name___________________ Father's full name__________________
Legal Guardian's full name (If not mother or father)________________________
Primary Insurance Holder for Patient______________________________________

Describe briefly your top 3 concerns today: ______________________________
____

Allergies: ____

Medications: *List prescriptions, over the counter medications and vitamins*

Name of drug	*Dose*

Pharmacy:____

Previous Surgeries:

Type	*Year*	*Reason*

Name___________________________ DOB ____________

Past medical History: *Please check all that apply*

	Aids/HIV		Drug Abuse		Pacemaker
	Alcohol Abuse		Eczema		Palpitations
	Allergies		Enlarged Prostate		Pneumonia
	Asthma		Fibromyalgia		Psoriasis
	Anemia		Gallbladder Disease		Sciatica
	Anxiety		GERD (Reflux)		Seizures
	Arthritis		Glaucoma		Sexual Dysfunction
	Atrial Fibrillation		Gout		Sleep Apnea
	Back Pain		Headaches		STD
	Blood Clots		Heart Attack		Stomach Ulcer
	Cancer		Heart Disease		Stroke
	Chest Pain		Heart Murmur		Swollen Ankles
	Congestive Heart Failure		Hemorrhoids		Thyroid Disease
	Constipation		Hepatitis C		Tuberculosis
	COPD		High Blood Pressure		Ulcerative Colitis
	Crohns's Disease		High Cholesterol		UTI (Recurrent)
	Depression		Kidney Stones		Other___________
	Diabetes Mellitus - Type I		Kidney Disease (Renal Insufficiency)		Other___________
	Diabetes Mellitus - Type II		Liver Disease		Other___________
	Diverticulitis		Osteoporosis		Other___________

Name__________________________ DOB ____________

Do Any Family Members Have a History of the Following:

Illness	Family Member	Age of Onset	Alive	Deceased
Diabetes				
High Blood Pressure				
Heart Disease / Bypass Surgery /Heart Attack				
Stroke				
Mental Disease / Anxiety / Depression				
Cancer (note type)_________________				
Drug / Alcohol Addiction				
Glaucoma				
Bleeding Disorder				
Blood Clots				
Other____________________________				
Other____________________________				

Safety: *Please Circle*

Do you wear a seat belt? YES NO

Are you exposed to second hand smoke? YES NO

Do you drink caffeinated beverages? YES NO

Have you had 2 or more falls in the past year? YES NO

If there is a gun in your home, is it stored unloaded in a secure location away from children? YES NO

Are you in an abusive relationship? YES NO If yes, circle VERBAL or PHYSICAL

Do you feel safe in your home? YES NO If NO, why?_____________________

Name________________________ DOB ___________

Personal History:

What is your highest education level? Grade ____ HIGH SCHOOL
SOME COLLEGE COLLEGE GRADUATE ADVANCED DEGREE

Do you have children? YES NO If YES, how many?_________

How often do you exercise each week? NONE OCCASIONAL
1-2 X/WEEK 2-3X/WEEK 3-4X/WEEK

What kind of exercise? ____

With whom do you currently live? ___________________________________

Marital Status? PARTNERED/ SIGNIFICANT OTHER NEVER MARRIED
MARRIED DIVORCED SEPERATED WIDOWED

Are you currently working? YES NO

What is your current or past occupation?______________________________

Social History:

Are you a SMOKER NON SMOKER

Current smoker: How often? DAILY NOT EVERY DAY

How many cigarettes/cigars? 5 OR LESS 6-10 11-20 21-30 31+

Former smoker: How long ago did you quit? __________________________

List any other tobacco use: ____

Are you sexually active? YES NO Partner preference MALE FEMALE BOTH

Do you use protection? YES NO Type______________________________

Did you have a drink containing alcohol in the past year? YES NO

How often do you drink alcohol? NEVER MONTHLY OR LESS
2-4/ MONTH 2-3/WEEK 4 OR MORE/WEEK

How many drinks on a typical day? 1-2 3-4 5-6 7-9 10+

How often have you had 6 or more drinks in one occasion? NEVER
LESS THAN MONTHLY MONTHLY WEEKLY DAILY

Do you use drugs for reasons that are not medical? YES NO
If YES, please list ____

Name__________________________ DOB ___________

Mood screening:

In the past 2 weeks do you report:

Little interest or pleasure in doing things? YES NO

Feeling down, depressed or hopeless? YES NO

Please complete the following questions if you are age 65+

Have you had 2 or more falls in the past year? YES NO

Females only:

Do you have urinary leakage when you laugh, cough or sneeze? YES NO

Do you ever have loss of bladder control? YES NO

Health Maintenance:

Males only: When was your last:

Prostate Exam_________________________

Colonoscopy __________________________

PSA Test______________________________

Flexible Sigmoidoscopy_________________

Hemocсult Cards_______________________

Females only: When was your last:

Pap Smear____________________________

Mammogram__________________________

Breast Exam __________________________

Bone Density Exam ____________________

Colonoscopy __________________________

Flexible Sigmoidoscopy ________________

Hemoccult Cards _______________________

Age menstrual cycle began:________________Frequency___________

Length of periods ______________ Last menstrual period _________