NORTHERN
Family Medicine
a department of Northern Regional Hospital

New Patient History Form

Name:_____ **Age:**_____ **Date of Birth:**____/___/_____ **Sex: M F**
M D Y

Reason for Visit:_____

PAST MEDICAL HISTORY: Have you ever had any of the following:

Check each item	No	Yes	Check each item	No	Yes	Check each item	No	Yes
Anemia			Depression			Mitral valve prolapse		
Anxiety			Diabetes			Osteoarthritis		
Asthma			Emphysema			Phlebitis		
Back disorder			Fibromyalgia			Pneumonia		
Blood clot			Gallstones			Rheumatoid arthritis		
Cancer			Heart attack			Seizure		
Cirrhosis			Hepatitis			Sleep Apnea		
Colitis			Hypertension			Stomach ulcer		
Colon Cancer			Kidney infection			Stroke		
Colon Polyps			Kidney stone			Thyroid trouble		
COPD			Liver Disease			Tuberculosis		
Coronary artery disease			Lupus					

List Medications you are currently taking, including over-the-counter or non-prescription.

NAME	Strength	How often taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SOCIAL HISTORY

Occupation:_____ ☐ **Retired** ☐ **Disabled** ☐ **Unemployed**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Number of children:_____ **Hobbies:**_____

Are you ☐ **Right-Handed** ☐ **Left Handed**

Are you an Athlete? ☐ **No** ☐ **Yes – What sport(s)?** _____

Level: ☐ **Recreational** ☐ **Middle School** ☐ **High School** ☐ **College**

Do you have any advanced directives? (Living Will, Health Care Power of Attorney, Do Not Resuscitate) If yes, please specify: _____

Do you have any cultural, religious or emotional concerns in regard to your healthcare? Yes or No. If yes, please explain. _____

Do you have any financial concerns in regard to your healthcare? Yes or No. If yes, please explain._____

Do you have access for adequate food/nutrition needs?_____

Do you feel that you understand the instructions that are given to you by your provider or pharmacist? Yes or No. If no, please explain._____

Are you an Organ Donor? Yes or No

Preferred Language for discussing your health care:_____

Are you now or have you ever been a victim of domestic violence/abuse? _____

Your Personal Habits: Do you….	No	Yes	Do you….	No	Yes
Regularly exercise (3-4 times weekly)			Use alcohol		
Wear auto seat belt (90% of time)			Smoke (if ever when did you stop?)		
Use illegal drugs					

Have you ever been evaluated by a Pain Management Specialist? Yes or No

Are you currently being seen by Pain Management? Yes or No. If Yes What Clinic? _____

Do you have Suicidal Thoughts or Tendencies? Yes or No

Do you have Problems Hearing? Yes or No

Do you have Problems with your Vision? Yes or No

FAMILY HISTORY: Do you have a family history of:

	No	Yes	Family Member		No	Yes	Family Member
Anesthesia Problem				Liver Disease			
Bleeding Problem				Osteoporosis			
Cancer (location)				Stomach Ulcers			
Cirrhosis				Stroke			
Colon Cancer				Thyroid Disease			
Colon Polyps				Mental Illness			
Diabetes				Other:			
Heart Disease				Other:			
High Blood Pressure							

ALLERGIES: List any medication allergies.

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

Please check if you are allergic to: ☐ **Eggs** ☐ **Iodine** ☐ **Shellfish**

Please list any food allergies: _____

Your hospitalizations: ☐ **None** **Year** **Hospital**

Illness: (kind) _____

_____ _____ _____

_____ _____ _____

Surgery: (kind) _____

_____ _____ _____

_____ _____ _____

Have you ever had a bone density test? ☐ **No** ☐ **Yes If yes, when?** _____

Have you ever been under the care of Pain Management? ☐ **No** ☐ **Yes If yes, when?** _____

	No	Yes			No	Yes	
		Now	In past			Now	In past
Fatigue				Changes in Mental Status			
Night Sweats				Seizures			
Double Vision				Joint Swelling			
Blurred Vision				Limited Movement			
Vertigo				Cold Intolerance			
Recent Head Injury				Heat Intolerance			
Chest Pain				Lymph node Enlargement or Tenderness			
Irregular Heart Beat				Frequent Illness			
Shortness of Breath				Other:			
Productive Cough				Other:			
Nausea				Are you having Pain Today? Yes or No			
Vomiting				Other:			
Difficulty Urinating				Other:			
Urine Retention				Other:			
Change in hair growth				Other:			
Sores on Skin				Other:			