Sacopee Valley Health Center
NEW PATIENT HISTORY FORM
Please Print

Today's Date: / / | Name: | DOB / /

1. Please list on-going, long term medical problems (chronic problems):

2. Please list past problems and surgeries you have had (past medical history):

3. Please list all current medications, vitamins, herbs and all over the counter medications with doses:

Name of Medication	Strength	When you take it

4. List medication allergies and your reaction to each:

5. List medical problems that run in your family. Check all that apply and write who was affected:

□ Asthma_____
□ Heart attacks/angina prior to age 65 male, age 55 female (premature)_____
□ Migraine headaches _____
□ Osteoporosis _____
□ Stroke (CVA) _____
□ Alcoholism_____
□ Drug abuse_____
□ Diabetes (adult onset) _____
□ High cholesterol (hyperlipidemia) _____
□ High blood pressure (hypertension) _____
□ ADD/ADHD_____
□ Depression_____
□ Significant mental illness other than depression _____
□ Other _____
Cancer:
□ Breast:_____
□ Colon:_____
□ Melanoma:_____
□ Ovarian:_____
□ Prostate:_____
□ Other _____

6. Health habit history (social history)

Occupation: _____
Martial status (circle): Single Married Divorced Widowed
Do you have children? (circle) Yes No #Sons_____ #Daughters_____
Have you ever used tobacco/nicotine (Cigarettes, Cigars, Chewing, E-Cigarette, Pipe, Vapor)? (circle) Current Former (Year quit_____) Never
* If current or former (circle) Type: Cigarettes Cigars Chewing E-Cigarette Pipe Vapor Age you started _____ Amount per day _____
Do you drink alcohol? (circle) Yes No Type_____ Frequency_____ Amount per day_____
Do you drink caffeine? (circle) Yes No Type_____ Amount per day_____
What is your activity level? (circle) Moderate Sedentary Vigorous
Do you have a living will or other advanced directive? (circle) Yes No **If yes please give us a copy for your record**

7. Confidential health habit history

Do you use recreational drugs? (circle) Yes No Type_____ Frequency_____
Do you have a history of being abused? (circle) Yes No
Have you been a victim of domestic violence? (circle) Yes No
Are you sexually active? (circle) Yes No
If so, do you engage in activity with? (circle) Men Women Both
What is your birth control type? _____

8. Health Maintenance - please list approximate dates of your last:

Colonoscopy: _____ Where was it done: _____
Mammogram: _____ Where was it done: _____
Pap smear: _____ Where was it done: _____
Flu shot:_____ Where was it done: _____
Pneumonia shot:_____ Where was it done: _____
Tetanus shot:_____ Where was it done: _____
Bone Density test (DEXA):_____ Where was it done: _____

9. Review of systems - If YES circle and list details

Constitutional
Chills Yes_____
Fatigue Yes_____
Fever Yes_____
Malaise (tired/ill feeling) Yes _____
Night sweats Yes_____
Weight gain Yes_____
Weight loss Yes_____
Other: _____

HEENT
Ear drainage Yes_____
Ear pain Yes_____
Eye discharge Yes_____
Eye pain Yes_____
Hearing loss Yes_____
Nasal Drainage Yes_____
Sinus Pressure Yes_____
Sore Throat Yes_____
Visual changes Yes_____
Other: _____

Respiratory
Chronic cough Yes_____
Cough Yes_____
Known TB exposure Yes_____
Shortness of breath Yes_____
Wheezing Yes_____
Other: _____

Cardiovascular
Chest pain Yes_____
Claudication (bad circulation) Yes_____
Edema Yes_____
Palpitations Yes_____
Other: _____

Gastrointestinal
Abdominal pain Yes_____
Blood in stools Yes_____
Change in stools Yes_____
Constipation Yes_____
Diarrhea Yes_____
Heartburn Yes_____
Loss of appetite Yes_____
Nausea Yes_____
Vomiting Yes_____
Other: _____

Genitourinary
Dysuria (painful urination) Yes_____
Hematuria (blood in urine) Yes_____
Polyuria (too much urine) Yes_____
Urinary frequency Yes_____
Urinary incontinence Yes_____
Urinary retention Yes_____
Dribbling Yes_____
Slow stream Yes_____
Other: _____

Reproductive
Abnormal pap Yes_____
Dysmenorrhea (painful period) Yes_____
Dyspareunia (painful intercourse) Yes _____
Hot flashes Yes_____
Irregular menses Yes_____
Vaginal discharge Yes_____
Erectile dysfunction Yes_____
Penile Discharge Yes_____
Sexual dysfunction Yes_____
Other: _____

Integumentary
Breast discharge Yes_____
Breast lump Yes_____
Brittle hair Yes_____
Brittle nails Yes_____
Hair loss Yes_____
Hirsutism (irregular hair growth) Yes _____
Hives Yes_____
Pruritis (itching) Yes_____
Mole changes Yes_____
Rash Yes_____
Skin lesion Yes_____
Other: _____

Neurological
Dizziness Yes_____
Extremity numbness Yes_____
Extremity weakness Yes_____
Gait disturbance Yes_____
Headache Yes_____
Memory loss Yes_____
Seizures Yes_____
Tremors Yes_____
Other: _____

Psychiatric Yes_____
Anxiety Yes_____
Depression Yes_____
Insomnia Yes_____
Other: _____

Metabolic/Endocrine
Cold intolerance Yes_____
Heat intolerance Yes_____
Polydipsia (drinking a lot of water) Yes_____
Polyphagia (eating a lot) Yes_____
Other: _____

Musculoskeletal
Back pain Yes_____
Joint pain Yes_____
Joint swelling Yes_____
Muscle weakness Yes_____
Neck pain Yes_____
Other: _____

Hematologic/Lymphatic
Easy bleeding Yes_____
Easy bruising Yes_____
Lymphadenopathy (swolen lymphnodes) Yes_____
Other: _____

Immunologic
Contact allergy Yes_____
Environmental allergies Yes_____
Food allergies Yes_____
Seasonal allergies Yes_____
Other: _____

Over the last two weeks have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things
□ Yes □ No

b. Feeling down, depressed, or hopeless
□ Yes □ No

Any other information for discussion?

SIGNATURE: