His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: ____ DOB: _______________

Medical Conditions:

Please list all major medical conditions, when they first started, and when they resolved, if appropriate, or check "None" if you have no ongoing conditions:

☐ None

	Condition or Diagnosis	*Date Started*	*Date Resolved*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Specialists involved in your care:

☐ None

	Specialist's Name	*Specialty*	*Condition*
1			
2			
3			
4			
5			
6			

Immunizations:

Please obtain and/or attach a copy of your immunization record, if possible.

Date of most recent Tetanus booster: ____________

Patient's Name: ____DOB: ______________

Medications:

Please list all prescriptions and any over the counter medications or herbal supplements you are taking, or check "None" if you are not taking any medicines or supplements:

☐ None

	Name of Medication	*Dose, e.g. 20 mg*	*How Often, e.g. 3x/day*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Primary Pharmacy:

Name____

Address____

Phone Number __________________________________

Allergies:

☐ None

	Medication, Food, or Substance	*Reaction*
1		
2		
3		
4		
5		
6		

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: ____DOB: ______________

Hospitalizations and Past Medical Conditions:

Please list all serious injuries, hospitalizations or surgeries (except Obstetrical History of pregnancies, see box below), including the approximate date or your age at the time, as best you can remember, or check "None" if appropriate:

☐ None

	Hospitalization, Surgery or Serious Injury	*Age or Date*
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Pregnancies:

☐ None ☐ Not applicable

	Date	*Weeks*	*M or F*	*Type of Delivery*	*Location*	*Complications*
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Total Pregnancies: ______ *Term births:* ______ *Preemies:* _____ *Miscarriages:* ______ *Abortions:* ______

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: ____DOB: _______________

Family History:

Your Relatives	Their Names	Birth Year	Year/Cause of Death	Medical Conditions? (Use Numbers listed below*)
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				
Mother's Mother				
Mother's Father				
Father's Mother				
Father's Father				
Other				

* List of Conditions (use numbers in boxes above)			
1	Heart Disease (CAD)	7	Colon cancer
2	Stroke (CVA)	8	Breast or Prostate cancer
3	Diabetes (DM)	9	Lung cancer
4	High blood pressure (HTN)	10	Emphysema (COPD)
5	High cholesterol (Chol)	11	Thyroid
6	Arthritis	12	Obesity
13	Other		

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: ____DOB: _______________

Review of Systems (Symptoms or Conditions you have now or have had in the past):

Condition	*Have now?*	*Had in past?*	*Notes*
CONSTITUTIONAL (GENERAL)			
Weight loss			
Weight gain			
Fever			
Fatigue			
EYES			
Double vision			
Spots before eyes			
Vision changes			
HEAD / EARS / NOSE / THROAT			
Headaches			
Ear aches			
Ringing in ears			
Hearing loss			
Sinus problems			
Sore throat			
Mouth sores			
Dental problems			
CARDIOVASCULAR (HEART)			
High Blood Pressure			
Chest pain			
Heart Disease / Heart Attack(s)			
Difficulty breathing			
Swelling of legs			
Heart palpitations			
Heart murmurs			
Rheumatic fever			
Stroke			
RESPIRATORY (LUNG)			
Wheezing			
Spitting up blood			
Shortness of breath			
Chronic cough			
Asthma			
TB or other lung			

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: ____DOB: ______________

Review of Systems (continued):

Condition	***Have now?***	***Had in past?***	***Notes***
GASTROINTESTINAL			
Nausea or vomiting			
Acid reflux or heartburn			
Stomach or intestinal problems			
Peptic ulcer disease			
Hepatitis, Mono, or liver problems			
Gall bladder disease			
Diverticulosis/itis			
Frequent diarrhea			
Constipation			
Bloody stool			
Colitis			
Colon Cancer			
GENITOURINARY			
Blood in urine			
Painful urination			
Urgency			
Urinary frequency			
Incomplete emptying			
Stress incontinence			
Abnormal periods			
Painful intercourse			
Loss of libido (interest in sex)			
Erectile dysfunction			
Sexually transmitted diseases			
Frequent vaginal infections			
Infection of uterus, tubes, ovaries			
Abnormal Pap smear			
Uterine or Ovarian Cancer			
SKIN / BREAST			
Pain in breast			
Nipple discharge			
Masses			
Breast Cancer			
Skin Rash or Ulcers			

Patient's Name: ____DOB: ______________

Review of Systems (continued):

Condition	*Have now?*	*Had before?*	*Notes*
NEUROLOGICAL			
Frequent severe headaches			
Dizziness			
Numbness			
Trouble walking			
Epilepsy / Convulsions			
MUSCULOSKELETAL			
Muscle weakness or cramps			
Joint problems			
Fibromyalgia			
MENTAL / EMOTIONAL HEALTH			
Mental or emotional problems			
Depression			
Crying frequently			
Hopelessness			
Fatigue			
Lack of motivation			
Poor concentration			
No interest in activities			
Marked decrease in sexual desire			
Exaggerated sexual desire			
Anxiety			
Irritability			
Panic attacks			
Insomnia			
Loss of appetite			
Increased appetite			
Suicidal thoughts			
Struggling with guilt			
ENDOCRINE (GLANDULAR)			
Dry skin			
Abnormal thirst			
Hot flashes			
Diabetes			
Thyroid Disease			

Patient's Name: ____DOB: _______________

Review of Systems (continued):

Condition	Have now?	Had in past?	Notes
HEMATOLOGICAL (BLOOD)			
Frequent bruises			
Cuts that do not stop			
Bleeding			
Enlarged lymph node			
Anemia (low blood count)			
Sickle Cell			
Blood clots or clotting disorder			
Varicose veins			
Leukemia or Hodgkin's Disease			
Other Cancer (what kind?):			

Nicotine Use:

Smoking Status:

☐ Never smoked ☐ Occasional smoker ☐ Everyday smoker ☐ Former smoker

If you were or are a smoker, what do you smoke?

☐ Cigarettes (#/day________) ☐ Cigars (#/day________) ☐ Pipe (#/day________)

Other Sources of Nicotine:

☐ Snuff ☐ Chewing tobacco ☐ E-cigarettes ☐ Nicotine gum

Other information: ____

____

____

____

____

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: ____DOB: _______________

Social History:

HABITS

Do you drink alcohol? Y N What? /How much? ______________________ Quit date?________

Caffeinated beverages? Y N What? /How much? ______________________ Quit date?________

Do you use drugs? Y N What? /How much? ______________________ Quit date?________

Do you exercise? Y N How? ______________ Days/week?_______ Minutes/day?_______

EDUCATION / EMPLOYMENT

How far did you go in school? Elementary High School Some College College Professional School

Name of College/Degree:____

Work (circle one): Full-time Part-time Unemployed Disabled Year last worked_______

Employer:_________________________________ Position:_________________________________

Military Service (circle one): None Army Navy Air Force Marines Coast Guard Merchant Marine

Year of draft or enlistment:____________ Year of discharge:___________

PERSONAL INFORMATION

Where were you born?____

Where were you raised?____

Ethnicity (circle one): Asian African American Caucasian Latino Other __________________

Living arrangements (circle one): Apartment Group home 1-story house 2-story house

Marital status (circle one): Single Married Separated Divorced Widowed

Sexual orientation (circle one): Straight Gay/Lesbian Bisexual Transgender

Have you ever had an STI/STD? Y N Kind/Date?____________________________________

Are you HIV positive (circle one): Y N Not tested

Faith (circle one): Catholic Protestant Evangelical Pentecostal Jewish Other:_____________

Place of worship: ____

Do you have any hearing or other communications barriers? _________________________________

Other information: ____

____

____

____

____

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: ____DOB: _______________

For Women Only:

MENSTRUAL HISTORY

How old were you when you started your first period? ____________________________

Do you have a period every month? Y N

Date of your last menstrual period (first day): ____________________________

Interval (number of days from the start of one period to the start of the next): ________________

Number of days of flow / bleeding: ____________________________

Do you have any of the following?

Cramps	Y N		Vaginal sores	Y N	
Discharge	Y N		Bleeding w/intercourse	Y N	
Vaginal odor	Y N		Painful intercourse	Y N	

Have you ever had a mammogram? Y N When? ________________________________

Have you ever had a pelvic exam? Y N

Date of last pap smear___________________ Normal / Abnormal Where? ______________________

Have you ever had an abnormal pap smear? Y N

Treatment/Date____

Do you douche/use feminine hygiene products? Y N How often? _________________________

CONTRACEPTIVE HISTORY: If Applicable

Have you ever used any birth control method to keep you from getting pregnant? Y N

What methods have you used in the past? (Check all that apply)

___ Withdrawal (pulling out)	___ Injections (Depo shot)	___ "Luck"
___ Oral (the pill)	___ Vaginal sponge	___ Abstinence
___ Condoms	___ Vasectomy	___ Rhythm (calendar)
___ Diaphragm	___ IUD (type: __________)	___ Natural Family Planning
___ Foam, jelly, cream	___Tubal ligation	___ Other ______________

What method are you currently using? ____

How long have you been using this method? ____

What method do you want to use now? ____

Age at your first sexual intercourse? ___________ Total # of sexual partners: ____________________

Are you trying to get pregnant? Y N For how long? ______________________________