ARIA COMMUNITY HEALTH CENTER

New Patient History Form

Name: ______________________ Date of Birth: ____________ Today's Date: ____________

How do you wish to be addressed? ______________________

Reason for today's visit: ______________________

Location of problem: ______________________

When did problem begin? ______________________ Was the onset of problem? Sudden Gradual

What makes it better? ______________________

What makes it worse? ______________________

How bad is problem on this scale ? 1 Less 2 3 4 5 6 7 8 9 10 Worse

How long does it last? ______________________ Is occurance of problem? Constant Intermittent

Overall, is it getting worse? Y N If yes, describe how? ______________________

Is it associated with anything else? ______________________

Medical History: Do you have any of the following conditions? (Circle Y for yes and N for No and explain below as needed)

Condition			Condition			Condition		
Cancer	Y	N	Diabetes	Y	N	Ovary problems	Y	N
Heart Disease	Y	N	Thyroid problems	Y	N	Bone problems	Y	N
Blood clots	Y	N	Elevated cholesterol	Y	N	Nerve problems	Y	N
Stroke	Y	N	Eye problems	Y	N	Anesthesia problems	Y	N
High Blood Pressure	Y	N	Kidney Disease	Y	N	Depression	Y	N
Birth defects	Y	N	Bladder problems	Y	N	Eating Disorders	Y	N
Skin Disorders	Y	N	Blood disorder	Y	N	History of sexual abuse	Y	N
Ulcers	Y	N	Infection	Y	N	Psychiatric disorder	Y	N
Liver problems	Y	N	Muscle weakness	Y	N	Lung problems	Y	N
Bowel Problems	Y	N	Problems with uterus	Y	N	Asthma	Y	N
Ear problems	Y	N	Abnormal PAP	Y	N	Arthritis problems	Y	N

Comments: ______________________

Medications: Are you taking any medication? Y N

Medication	Dosage	Reason for Medication and Prescribing Doctor

Comments:

Allergies: Y N

Medication	Reaction

Comments:

Surgical history: Have you had any surgery? Y N

List any surgeries you have had and the approximate date. (Example: Tonsillectomy, appendectomy, gallbladder, tubal ligation, breast surgery, laparoscopy, hysterectomy, bladder surgery.)

Date	Surgery, Reason for surgery, Location of surgery

Comments: ____

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OB History:

Pregnancies	Miscarriages	Abortions	Mult. Births	Live Births	Children living with you	Living children

Name of child						
Name of Father						
DOB						
Wks @ Delivery						
Weight						
Sex						
Delivery Type						
Place of Delivery						
Depression w/ pregnancy or postpartum?	Y N	Y N	Y N	Y N	Y N	Y N
Complications? If yes, explain below.	Y N	Y N	Y N	Y N	Y N	Y N

Complications / Comments: ____

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____

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Review of systems:

Fever	Y	N	Glaucoma	Y	N	Positive TB test	Y	N
Recent Weight change	Y	N	Ear pain	Y	N	Coughing blood	Y	N
Fainting spells	Y	N	Loss of hearing	Y	N	Wheezing	Y	N
Head Injury	Y	N	Lumps in throat	Y	N	Short of Breath	Y	N

Symptom	Y	N
Swelling in your legs	Y	N
Chest Pain	Y	N
High Blood Pressure	Y	N
Abdominal pain	Y	N
Change in your stool	Y	N
Irritable Bowel	Y	N
Constipation	Y	N
Diarrhea	Y	N
Vomiting	Y	N
Heart burn	Y	N
Rectal bleeding	Y	N
Back problems	Y	N
Paralysis	Y	N
Restricted motion	Y	N
Weakness	Y	N
Memory loss	Y	N
Behavioral change	Y	N
Mood Change	Y	N
Anxiety	Y	N
Breast mass	Y	N
Breast Pain	Y	N
Breast discharge	Y	N
Eczema	Y	N
New skin lesion	Y	N
New skin lumps	Y	N
Change in mole	Y	N
Rash	Y	N
Fainting spells	Y	N
Headaches	Y	N
Muscle weakness	Y	N
Anemia	Y	N
Easy bruising	Y	N
History of Transfusion	Y	N
Coughing	Y	N
Hives	Y	N
Burning with urination	Y	N
Kidney stones	Y	N
Blood in urine	Y	N
Trouble urinating	Y	N
Painful urination	Y	N
Urinating frequently	Y	N
Leaking urine	Y	N
Nighttime urination	Y	N
Hot Flashes	Y	N

Gynecological History:

If you are having periods: (if not having periods, skip to next section below)

Age when you had your first period? __________ Is your menses monthly? Y N

When was your last period? __________________ How many days do your periods last? __________

Cramps? ☐ Not bothersome ☐ Bothersome **Clots?** ☐ Some ☐ Moderate ☐ Abundant

Flow? ☐ Mild ☐Moderate ☐Heavy **Are you using birth control?** Y N **What kind? (choose one below)**

Pills tubal ligation vasectomy Depo Shot IUD Implant Condoms Other: ______________

If you are not having periods:

When was your last period? ___________ Are you in menopause? Y N Have you taken any hormones? Y N

Are you having any irregular spotting or bleeding? Y N

When was your last Pap smear? __________________________ Normal Abnormal: ___________________________

Have you ever had any abnormal PAP smears? Y N

Have you had treatment for an abnormal Pap smear? Y N

Have you received HPV vaccine (Gardasil)? Y N If yes, when was last dose? _________________________

Have you ever been treated for any sexually transmitted infection? Y N

Gonorrhea   Chlamydia   syphilis   herpes   genital warts   PID   Other: ____________________

Have you ever been tested for HIV?   Y   N   Date of last test:____________ Result: Negative   Positive

Are you currently sexually active?   Y   N   Partners are: ☐ Men   ☐ Women   ☐ Both

At what age did you become sexually active? __________ How many lifetime sexual partners have you had? ________

Have you had a new sexual partner in the last year?   Y   N

Are you experiencing any sexual problems?   Y   N

Have you ever been told you have fibroids of the uterus?   Y   N

Have you ever had any ovarian cysts?   Y   N

Health maintenance:	**Date**	**Results**
Last bone density?	________	____________________
Last cholesterol?	________	____________________
Last colonoscopy?	________	____________________
Last mammogram?	________	____________________

Have you ever had an abnormal mammogram?   Y   N

Have you ever had a breast biopsy?   Y   N

Social History:

Occupation: ______________________________ ☐ Full-time   ☐ Part-time   ☐ Days   ☐ Nights   ☐ Swing

Highest Level of Education: ____________________ Who lives with you? ____________________________

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

Tobacco use?   Y   N   how many packs/day_____   Number of years of use?_____ Quit what year? ________

Alcohol use?   Y   N   Number of drinks per week ______   Type: ☐ Beer   ☐ Wine   ☐ Liquor

Caffeine use?   Y   N   How many cups in 1 day?_____

Exercise?   Y   N   Number of times per week? ______   Type: ____________________________

Seat belt use?   Y   N

Any dietary restrictions?   Y   N   If yes, describe: ____________________________

Recreational Drug use?   Y   N   If yes, what type? ____________________________

Will you accept blood transfusion in an emergency?   Y   N

Do you have advanced directive or living will?   Y   N

Do you have a durable power of attorney? Y N

Do you have a do not resuscitate document? Y N

Comments: ______________________________

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Family History:

Mother ☐ Living ☐ Deceased ______________________________

Father ☐ Living ☐ Deceased ______________________________

Any family history of:

Diabetes	Y	N	Who: ______	Bladder cancer	Y	N	Who: ______
Thyroid disease	Y	N	Who: ______	Osteoporosis	Y	N	Who: ______
Breast cancer	Y	N	Who: ______	Genetic disorder	Y	N	Who: ______
Uterine cancer	Y	N	Who: ______	Psych. illness	Y	N	Who: ______
Cervical cancer	Y	N	Who: ______	Other	Y	N	Who: ______
Colon cancer	Y	N	Who: ______	Explain: ______			
Ovarian cancer	Y	N	Who: ______				

By signing below, I certify that the information provided above is true and correct to the best of my knowledge.

______________________________ ______________________________

Signature Date