CareHere!

New Patient Paperwork

Patient Information:

First: _____ Middle: _____ Last: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____ Marital Status: M S D W

Address: _____

City / State / Zip: _____ Email address: _____

Phone: (H): _____ (C): _____ (W): _____

Emergency Contact: _____ Phone: _____

Medical, Surgical, Social, & Family History

List Medication Allergies: _____

List all Current Medication (prescriptions, OTC, hormones, herbal remedies)

Pharmacy

(Please list name and street): _____

Patient Health History

☐ No History of Illness

☐ ADHD ☐ Autism ☐ Hearing Loss

☐ Allergies (Seasonal) ☐ Heart Attack

☐ Arthritis ☐ Heart Burn (acid reflux)

☐ Asthma ☐ High Blood Pressure

☐ Bipolar ☐ High Cholesterol

☐ Cancer (location? _____)

☐ Congestive Heart Failure ☐ Interstitial Cystitis

☐ COPD / Emphysema ☐ Kidney Stones

☐ Crohn's ☐ Migraine Headaches

☐ Depression / Anxiety ☐ Gout

☐ Diabetes ☐ Seizures

☐ Diverticulitis ☐ Stomach Ulcers

☐ Stroke ☐ Fibromyalgia

☐ Hypothyroid ☐ Hyperthyroid

Health Maintenance

Date of last Complete Physical: _____

Date of last cholesterol screen: _____

Date of last Tetanus shot: _____

Date of last Flu shot: _____

Date of last Pneumovax shot: _____

Date of last colonoscopy: _____

Date of last dental exam: _____

Women only: Last Period _____

Date of last Pap: _____ Normal Y / N

Last mammogram: _____Normal Y / N

Pregnancies: ____ # vag deliveries: _____

c-sec: _____ # miscarr: ___ # abort: ____

Menopause: Y / N Year: _____

Hysterectomy: Y / N Year: _____

Other: _____

_____

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Patient Name: _____ DOB: _____

Patient Surgical History (List Year of Surgery)

☐ No History of Surgery
☐ Appendix Removed
☐ Artificial Joints _____
☐ C-Section
☐ D & C
☐ Ear Tubes
☐ Gall Bladder Removed
☐ Hernia
☐ Hysterectomy (Partial / Total)
☐ Mastectomy
☐ Pace Maker
☐ Pins or Plates inserted (location: _____)
☐ Spleen Removed
☐ Thyroid Removed
☐ Tonsils Removed
☐ Tubal Ligation

Other: _____

_____

Family Health History

Father

List any health problems: _____

☐ No Known Health Problems ☐ Has Died – Age and Cause of Death: _____

Paternal Grandmother _____ Paternal Grandfather: _____

Mother

List any health problems: _____

☐ No Known Health Problems ☐ Has Died – Age and Cause of Death: _____

Maternal Grandmother _____ Maternal Grandfather: _____

Brothers / Sisters

How Many? _____ ☐ No Known Health Problems ☐ List any health problems: _____

☐ Has Died – Age and Cause of Death: _____

Social History

Alcohol Use? No Yes Beer / Liquor / Wine Average amount _____ Day / Week / Month / Year
Smoke or Tobacco Use: No Yes How many packs per day? _____ Smokeless Tobacco: Yes / No
Recreation Drug Use: No Yes If yes, please list: _____
Caffeine (soda, tea, coffee)? No Yes Average amount _____ Day / Week / Month / Year
Exercise No Yes How often? _____ Type: _____

Please describe any other information that you feel your healthcare provider should know:

_____

Name of person documenting above information (if other than patient): _____

Provider Signature: _____ Date: _____