

# CONFIDENTIAL



## New patient health history General information

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

Nickname/Preferred Name you would like us to call you: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

**Is it ok to leave a personal detailed message at one of these numbers? Y N Which one? \_\_\_\_\_**  
**Would you like to receive communications by unsecured email? Y N**  
**If yes, what is your email address? \_\_\_\_\_**

Relationship status:  Single  Married  Partnered  Separated  Divorced  Widowed

Living situation:  alone  friends  partner  spouse  parents  children

If you have children, please list names and ages: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer address \_\_\_\_\_

Employment status:  full-time  part-time  school  retired  unemployed other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Name of Partner/Spouse/Parent: (Circle one) \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

How did you hear about us? Phone book \_\_\_\_\_ Insurance \_\_\_\_\_ Other \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

I hereby authorize the release of any medical information necessary to in the processing of my medical claim. I also authorize payment directly to Integrative Primary Care Associates for the medical benefits.

I authorize my practitioner to examine and treat me, to consult with another healthcare practitioner in regards to continuing my care.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Patient, parent or guardian of minor

Who was your previous healthcare provider? (Please have copies of important prior records sent to us)

\_\_\_\_\_  
Name Address Phone Number

In your opinion, what are your most important physical, emotional, or mental health problems? Indicate which is/are of the most immediate concern to you.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Do any of your concerns that you would like us to address involve pain? **Y N**

Is your "main" concern related to any of the following?

- \_\_\_\_\_ Motor vehicle accident  
\_\_\_\_\_ Work related injury  
\_\_\_\_\_ Other accident or injury

How do you rate your overall health? Excellent Good Fair Poor

What are your expectations for today's visit? \_\_\_\_\_

What are your expectations for our work together in general?  
\_\_\_\_\_

---

## Prescription Medications You Are Currently Taking

(both regularly scheduled and ones taken as needed; there is additional space at end of form if you need it)

Name of Medicine	Dose	How Often You Take It	What You Take It For
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Non-Prescription Medications, Vitamins, Herbs, Supplements You Are Currently Taking (both regularly scheduled and ones taken as needed)

Name	Dose	How Often You Take It	What You Take It For
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Allergies (to medications, food, other allergens)

Allergen	Reaction	Allergen	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Hospitalizations/Surgeries/Procedures

Date	Description	Hospital, City
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Special studies

What diagnostic imaging studies have you had?  
(i.e. X-rays, CT scan, mammogram, MRI, bone density scan, EKG, EEG)

Date	Description	Reason for study
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Blood work

Date of last blood test? \_\_\_\_\_ What tests did you have (if known)

---

## Childhood Illnesses

Rubella (german, 3 day measles) _____	Measles (two week) _____	Roseola _____
Whooping cough _____	Chicken pox _____	Mumps _____
Rheumatic Fever _____	Asthma _____	Polio _____
Scarlet Fever _____	Diphtheria _____	

## Immunizations

Polio	Y	N	Pertussis	Y	N
Tetanus (Date of last: _____)	Y	N	Diphtheria	Y	N
Measles/Mumps/Rubella (MMR)	Y	N	Pneumonia	Y	N

Others \_\_\_\_\_

## Your health history

Now	Past	Never		Now	Past	Never	
___	___	___	Allergies	___	___	___	Heart Murmur*
___	___	___	Anemia	___	___	___	High Blood Pressure
___	___	___	Arthritis	___	___	___	Injury (serious)
___	___	___	Asthma	___	___	___	Kidney Disease
___	___	___	Alcoholism	___	___	___	Liver Disease
___	___	___	Bleeding problem	___	___	___	Overweight
___	___	___	Cancer	___	___	___	Pneumonia
___	___	___	Candida (yeast)	___	___	___	Polio
___	___	___	Colitis	___	___	___	Rheumatism
___	___	___	Drug abuse	___	___	___	Thyroid Problem
___	___	___	Eczema	___	___	___	Tuberculosis
___	___	___	Emphysema	___	___	___	Sexually Trans. Disease
___	___	___	Headache	___	___	___	Others*

\*Please specify

Frequent ear infections, colds or skin problems as a child? \_\_\_\_\_

Any difficulties with your birth or your mother's pregnancy? \_\_\_\_\_

## Family history

Is your mother living? **Y N** If yes, how old is she? \_\_\_\_ If no, age and cause of death and major medical problems: \_\_\_\_\_

Is your father living? **Y N** If yes, how old is he? \_\_\_\_ If no, age and cause of death and major medical problems: \_\_\_\_\_

Please list each brother and sister by age and medical problems:

\_\_\_\_\_

What blood relatives have had any of the following medical problems: high blood pressure, diabetes, angina, heart attack/myocardial infarction, stroke, tuberculosis, osteoporosis?

\_\_\_\_\_

Please list blood relatives with a history of cancer and what type of cancer:

\_\_\_\_\_

Have any blood relatives had medical problems before the age of 40 years? **Y N** If yes, which relative and what medical problem?

\_\_\_\_\_

Do you have an identical twin? **Y N** If yes, list their medical problems:

\_\_\_\_\_

## Advanced Directive

Do you have an Advance Directive? **Y N** If yes, please bring us a copy to keep in your chart.

If no, would you be interested in receiving more information about this? **Y N**

## Health and Lifestyle Inventory

### Weight

What do you consider is your ideal weight? \_\_\_\_\_

Are you: \_\_\_\_\_ at that weight \_\_\_\_\_ underweight \_\_\_\_\_ overweight ?

What health problems, if any, do you attribute to your weight?

---

What contributes to problems with your weight? (e.g. travel, snacks, business meals, emotions, lack of exercise, pregnancy) \_\_\_\_\_

Are you trying to lose or gain weight now? **Y N** If yes, how? \_\_\_\_\_

---

Have you ever had an eating disorder? **Y N** If yes, specify: \_\_\_\_\_

### Diet

Do you think you eat a healthy diet in general? **Y N**

Do you follow a particular diet? \_\_\_\_\_

Describe a typical:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

List common snacks: \_\_\_\_\_

How many caffeine containing drinks do you consume daily (coffee, tea, sodas)? \_\_\_\_\_

How many sodas do you drink a day and which ones? \_\_\_\_\_

Do you drink wine, beer or hard liquor? **Y N** If yes, which ones, how many glasses and how often?

---

### Exercise

How often do you exercise?

Never  Rarely  1 to 3 times a month  1 to 3 times a week  4 to 6 times a week  Daily

Average time per session: \_\_\_\_\_ How strenuous?  Mild  Moderate  Vigorous

What kind of exercise do you do? \_\_\_\_\_

What symptoms, if any, do you have when you exercise?

---

## Tobacco and other Substance Use

Do you currently smoke cigarettes? **Y N** If yes, how many a day? \_\_\_\_ How many years have you smoked? \_\_ If you don't smoke now, have you smoked in the past? **Y N** If yes, how many a day?

\_\_\_\_  
For how many years? \_\_\_\_ When did you quit? \_\_\_\_\_

Have you or do you smoke a pipe or cigar? **Y N** Chew tobacco? **Y N**

Are you exposed to second hand smoke? **Y N**

Are you currently using any of the recreational drugs below? **Y N** If yes, which ones:

marijuana  cocaine  methamphetamine  heroin  Other:

\_\_\_\_\_  
Have you ever been concerned about your alcohol, recreational or prescription drug use? **Y N**

Has anyone ever expressed concern about your alcohol, recreational or prescription drug use? **Y N**

Have you ever had legal problems related to your alcohol or drug use? **Y N**

## Stress

Do you sleep well at night? **Y N** If no, do you:

have trouble falling asleep  wake up in the middle of the night  wake up too early

How many hours do you sleep at night? \_\_\_\_\_

How would you rate the current stress level in your life?  None  Mild  Moderate  A lot

Is there a major source of stress in your life? **Y N** If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
During the past month, have you often been bothered by feeling down, depressed, or hopeless? **Y N**

During the past month, have you often been bothered by little interest or pleasure in doing things? **Y N**

If you answered yes to either of the above 2 questions, please ask for our Mood Assessment Form.

## Sexual Activity and Risk Profile:

What is your gender identity:  Female  Male  Male to Female  Female to Male  Other: \_\_\_\_\_

Have you ever been sexually active? **Y N** If yes, have you had sex with  Men  Women  Both

How many sexual partners have you had?  1-5  6-20  20+

Are you currently sexually active? **Y N** Are you using contraception? **Y N**

If yes, what: \_\_\_\_\_

Do you use latex condoms during intercourse? **Y N**

Have you ever been tested for HIV? **Y N** Date of last test: \_\_\_\_\_ Pos Neg

Have you ever had or been treated for sexually transmitted infections? **Y N**

Have you had genital warts? **Y N** Genital herpes? **Y N** Do you have any STD symptoms or concerns? **Y N**

Have you ever used intravenous drugs? **Y N** Ever had a blood transfusion? **Y N**

If yes, what year: \_\_\_\_\_

**For Women:**

When was your last Pap smear? \_\_\_\_\_ What was the result? \_\_\_\_\_

Have you ever had an abnormal Pap? **Y N** If yes, when? \_\_\_\_\_

Have you ever had a procedure done on your cervix? **Y N**

If yes, what: \_\_\_\_\_

Have you had a mammogram? **Y N** if yes, date of most recent: \_\_\_\_\_ Result: \_\_\_\_\_

Have you ever had an abnormal mammogram? **Y N** If yes, what was done and what was the outcome: \_\_\_\_\_

If you are > 60 years old, have you ever had a Bone Density Study? **Y N** Result: \_\_\_\_\_

Have you had a colonoscopy? **Y N** If yes, date of most recent: \_\_\_\_\_ Result: \_\_\_\_\_

**For Men:**

Do you do a testicular self exam monthly? **Y N**

If you are > 50 years old, have you had:

A Digital Rectal Exam of your prostate? **Y N** If yes, result: \_\_\_\_\_

A PSA blood test? **Y N** If yes, result: \_\_\_\_\_

Have you had a biopsy of your prostate? **Y N** If yes, result: \_\_\_\_\_

Have you had a colonoscopy? **Y N** If yes, date of most recent: \_\_\_\_\_ Result: \_\_\_\_\_

Other information you feel would be helpful for us to know about you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_