StoneBrooke family physicians

Patient Name: _____

New Patient History 12 Years and Older

DOB: _____ Date: _____

MEDICAL	☐ See List

MEDICATION NAME	DOSE	DIRECTION	FOR WHAT MEDICAL CONDITION

Do you have any other medical problems not listed above?

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING?			
HEALTH MAINTENANCE	**DATE/YEAR**	**LOCATION**	
Tetanus Vaccine			
Pneumonia Vaccine			
Shingles Vaccine			
Influenza Vaccine			
HEALTH MAINTENANCE	**DATE/YEAR**	**LOCATION**	**RESULTS**
Colonoscopy			
Mammogram			
Pap Smear			
Bone Density Test			

Do you currently use tobacco?	☐ Never user	☐ Former user	☐ Current everyday user	☐Current someday user
What kind of tobacco?	☐ Cigarettes	☐Cigars	☐Chewing tobacco	☐Other
At what age did you start smoking?		At what age did you quit smoking?	Do you consume alcohol? Yes ☐ No ☐	
How much tobacco do you use per day?	_____packs per day	_____cans of smokeless tobacco per day	How much per day_____week_____month_____	

SURGERIES/OPERATIO	RGERY/OPERATION

DRUG ALLERGIES	☐ No Drug Allergies

FAMILY HISTORY

Please list any family members in your ***IMMEDIATE*** family with any of the following medical issues		LIVING? YES OR NO **(If deceased, what age)**
Hypertension (high blood pressure)		
Hypercholesterolemia (high cholesterol)		
Diabetes		
Heart Disease/Heart Attack		
Cancer and Type		

Other:		

MEDICATION	REACTION