Medical Health History Form – New Patient

If YOU or YOUR IMMEDIATE FAMILY MEMBERS have had any of the following, please indicate yes in the appropriate column.

	You	Family Member
ADD/ADHD		
Anemia		
Allergies/Hay Fever		
Asthma		
Arthritis		
Anxiety/Depression		
Alcoholism		
Blood Clots		
Cancer		
Type 1 or 2 Diabetes		
Fractures		
Gynecological Disease		
High Blood Pressure		
High Cholesterol		
Heart Attack		
Kidney Disease		
Liver Disease		
Neurological Disease		
Osteopenia/Osteoporosis		
Respiratory Disease		
Skin Disease		
Stomach/Colon Disease		
Stroke		
Seizure Disorder		
Thyroid Disorder		
Sexually Transmitted Diseases		
Other – please list		

Please list any **SURGERIES / HOSPITALIZATIONS** you have had in the past: ________________

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Social Information

How you live your life affects your health. We want to give you the best health care possible. To do that, we are asking you questions of a personal nature. The more we know about you, the better care we can provide. The questions below are based on what health care experts recommend we ask our patients.

Depression Screening

In the last 2 weeks, have you had little/no interest in doing things you normally enjoy?
(For example: spending time with friends or playing sports.) ☐ Yes ☐ No
In the last 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No

Sexual Orientation/Gender Identification

Do you consider yourself: □ Straight (heterosexual) □ Bisexual □ I choose not to answer
□ Something else: ______________________ □ Lesbian or Gay (homosexual) □ Don't know
Are you: □ Male □ Female □ I choose not to answer □ Transgender Male (female to male)
□ Transgender Female (male to female) □ Other: _______________________
Are you sexually active? ❑ Yes ❑ No
If yes, do you have ❑ one partner ❑ multiple partners

Smoking and Recreational Drug and Alcohol Use

Tobacco use.

1. Are you a: ❑ Current smoker ❑ Former smoker ❑ Never smoked
2. Does anyone smoke cigarettes/other tobacco products where you live? □ Yes □ No
3. How long has it been since you last smoked?
   ❑<1 month ❑1-3 months ❑3-6 months ❑6-12 months ❑1-5 years ❑5-10 years ❑ >10 years
4. Are you: ❑ ready to quit ❑ thinking about quitting ❑not ready to quit
5. How many cigarettes a day do you smoke (20 cigarettes in one pack)?
   ❑ 5 or less ❑ 6-12 ❑13-19 ❑1 pack ❑2 packs per day ❑ >2 packs per day
6. How often do you smoke? ❑Every day ❑sometimes but not everyday
7. What was the approximate date when you started smoking? ______________
8. Do you chew tobacco or use snuff? □ Yes □ No
9. Do you use e-cigarettes or vape? ❑ Yes ❑ No
10. Do you drink alcohol? ❑ Yes ❑ No
11. If yes, I have: ❑ 1-2 drinks a month ❑1-2 drinks a week ❑1-2 drinks a night
    ❑ more than 2 drinks a day ❑ weekend binge drinking
12. Have you ever felt you should cut down on your drinking? ❑ Yes ❑ No
13. Have people annoyed you by criticizing your drinking? ❑ Yes ❑ No
14. Have you ever felt bad or guilty about your drinking? ❑ Yes ❑ No
15. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? ❑ Yes ❑ No
16. Are you a recovering alcoholic? ❑ Yes ❑ No
17. Do you use recreational (street) drugs? ❑ Yes ❑ No
18. Which of the following recreational/street drugs do you use?
    ❑ Marijuana ❑ Cocaine ❑Narcotics (pain pills) ❑Crack ❑Heroin ❑LSD ❑Meth ❑ Other
19. How often do you use recreational (street) drugs?
    ❑ Occasionally ❑Once a month ❑Once a week Daily
20. Have you used recreational (street) drugs in the past? ❑ Yes ❑ No
21. How long has it been since you used recreational (street) drugs?
    ❑ <1 month ❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ 1-5 years ❑ 5-10 years ❑ >10 years
22. Which of the following recreational/street drugs did you use?
    ❑ Marijuana ❑ Cocaine ❑Narcotics (pain pills) ❑Crack ❑Heroin ❑LSD ❑Meth ❑ Other
23. Do you exercise? ❑ Yes ❑ No
24. What do you do for exercise?
    ❑ Walk/Jog/Run ❑ Ride bike ❑ Lift weights ❑Exercise machine, exercise class (karate, yoga)
    ❑Other
25. How often do you exercise?
    ❑ Daily ❑ 1-2 times a week ❑ 3-4 times a week ❑ 5-6 times a week
26. Do you drink caffeinated products (tea, coffee, sodas, energy drinks)? ❑Yes ❑No
27. How much do you drink of caffeinated products?
    ❑1-2 cups a day ❑3-5 cups a day ❑ >5 cups a day ❑ 1-2 times a week ❑ 3 or more times week

28. Are you: Married Single Divorced Widowed Other____________________
29. Do you live alone? ☐ Yes ☐ No
30. If no, please indicate who you live with: Spouse Partner Family Other______________
31. Do you have a job? ☐ Yes ☐ No
32. What do you do for work? ❑ Poultry plant ❑ Manual labor (waterman, farmer, nursery, construction) ❑Office work ❑ Health care ❑ Truck driver ❑ Education ❑ Other
33. Are you exposed to any hazardous materials at your job?☐ Yes☐ No
    If yes, what materials? Metals Asbestos Agriculture/Pesticides
34. Please list the highest grade that you completed in school?
    ❑Elementary (Grades 1-5) ❑ Middle school (Grades 6-8) ❑Some high school ❑GED ❑High School degree/diploma ❑Certification ❑ Some college ❑College Degree
35. Does your religion affect your health care decisions? ❑ Yes ❑ No
36. Have you traveled outside the U.S. in the last year? ☐ Yes ☐ No
37. Have you spent time in prison? ☐ Yes ☐ No
38. Have you been to the dentist in the last year? ❑ Yes ❑ No
39. Where do you go to the dentist? ❑Eastern Shore Rural Health ❑Other provider
40. Date/year of last dental visit?____________
41. Do you have a living will/advanced directive? ❑ Yes ❑ No (If yes, please provide us a copy)

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so): Any Allergies to Medication or Food (list reactions):

Medication	Dose	Route	Frequency

Allergies:

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Preferred Pharmacy:

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