SSMHealth WCH Washington County Hospital & Medical Group

New Patient History Form

Patient information

Today's Date _____ Date of Birth _____

Name _____ Age _____

Previous Primary Care Provider (if any) _____

Other Physicians involved in your care (List name, specialty, town/phone/fax)

_____ _____

_____ _____

What pharmacy do you use? _____

Intake

Reason for today's visit _____

Medication List (Please list medicine name, dose, frequency and prescriber. Include over-the-counter medications)

_____

_____

_____

_____

_____

_____

Allergies (Medication/Food - indicate reaction symptoms)

_____

_____

_____

Circle symptoms below if experienced in the last 1-2 weeks

Chills	Wheezing	Increased urination	Anxiety
Fatigue	Chest pain	Urinary frequency	Depression
Fever	Leg pain	Urinary incontinence	Insomnia
Malaise	Leg swelling	Urinary retention	Cold intolerance
Night sweats	Palpitations	Hair loss	Heat intolerance
Weight gain	Abdominal pain	Itching	Increased thirst
Weight loss	Blood in stools	Mole changes	Increased hunger
Ear pain/problems	Change in stools	Rash	Back pain
Eye pain/problems	Constipation	Skin lesion	Joint pain
Hearing loss	Diarrhea	Dizziness	Joint swelling
Nasal drainage	Heartburn	Extremity numbness	Muscle weakness
Sinus pressure	Loss of appetite	Extremity weakness	Neck pain
Sore throat	Nausea	Gait disturbance	Easy bruising
Vision changes	Vomiting	Headache	Easy bleeding
Chronic cough	Pain/burning with	Memory loss	Swollen glands
Cough	urination	Seizures	
Shortness of breath	Blood in urine	Tremors	

SSMHealth WCH Washington County Hospital & Medical Group

Histories

Medical History – please circle if you have a history of the following and write year of diagnosis

Allergies	Cancer	Gallbladder disease	Irritable bowel
Anemia	Cardiac arrhythmia	GERD/acid reflux	disease
Angina	COPD	Migraine headache	Heart attack
Anxiety	Coronary artery	Heart disease	Osteoporosis
Arthritis	disease	Heart valve disorder	Renal/kidney disease
Asthma	Depression	Hepatitis/liver disease	Seizure disorder
Atrial fibrillation	Diabetes	Hypertension	Stroke
Blood clots	Elevated cholesterol		Thyroid disease

Other /not listed above (please explain) _____

_____

Females ONLY – OB/GYN History

Age of first period _____ Date of last menstrual period _____

Are your periods regular? (Circle) Yes No

Number of pregnancies _____ Number of deliveries _____

Vaginal delivery/C-section _____ Number of miscarriages/abortions _____

Form of contraception used _____

Date of last Pap test/what clinic _____

Have you ever had an abnormal Pap? (Circle) Yes No

Surgical History – please circle and write year of surgery

Appendectomy	Carpal tunnel release	Hysterectomy
Arthroscopy	Cataract removal	Knee replacement
Back surgery	Cholecystectomy (gallbladder)	LASIK
Bilateral tubal ligation	Colostomy	Mastectomy
Blood transfusion	D&C	ORIF (fracture repair)
Breast augmentation	Gastric bypass	Thyroidectomy
CABG (heart bypass)	Hernia repair	Tonsillectomy
Cardiac pacemaker	Hip replacement	

Other/not listed above (please explain) _____

_____

_____

_____

Family History - Please list medical history for family members

Father _____

Mother _____

Siblings' _____

Paternal Grandmother _____

Paternal Grandfather _____

Maternal Grandmother _____

Maternal Grandfather _____

SSMHealth WCH Washington County Hospital & Medical Group

Social History

Have you ever used tobacco? _____ Quit date _____
If no, are you exposed to second hand smoke? _____
If yes, did you smoke or chew or both? _____
How many years using tobacco? _____ How many cigarettes smoked per day? _____
Do you drink alcohol? (Circle) Yes No Formerly
How many drinks per week? _____
Do you consume caffeine? (Circle) Yes No
Any recreational drug use? (Circle) Yes No
Occupation _____
At risk for falls? (Circle) Yes No
Falls in the last year? (Circle) Yes No
Did fall result in injury? (Circle) Yes No
Recent travel (circle) None Out of state Out of country

Health Maintenance

Please write down the last time these health maintenance exams were performed.

Lab work: _____ Colonoscopy: _____

Influenza Vaccine: _____ Pneumonia Vaccine: _____

Tetanus Vaccine: _____ Zoster: _____

Mammogram: _____ DEXA scan: _____

PSA: _____

What would exceptional care mean to you? (ex: prompt med refill; easily accessible appointment slots)

_____

_____

_____