

## SFM New Patient Health History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Language** (*Check one box*):  English  Indian  Spanish  Russian  Other

**Race** (*Check one box*):  American Indian/Alaska Native  Asian  Hawaiian/Pacific Islander

White  Black/African American  Hispanic/Latin  Other  Refuse to Report

**Ethnicity** (*Check one box*):  Hispanic/Latin  Not Hispanic/Latin Race  Refuse to Report

Pharmacy/Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Medication Allergies and Reactions: \_\_\_\_\_

Please list current medications below:

Medication	Dosage	Frequency	Reason Taken

Please list any current or past medical illnesses for which you have been treated:

Please list any surgeries or hospitalizations:

Family History (*Please mark all that apply*):

- |  |   |                                    |   |
|--|---|------------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures       |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Ulcers    | <input type="checkbox"/> Mental Illness |

Social History:

Do you smoke or use tobacco products?    Yes   No    Packs per day \_\_\_\_\_ Years \_\_\_\_\_  
 Do you drink alcohol?    Yes   No    How much? \_\_\_\_\_  
 Do you use recreational drugs?    Yes   No    Which ones? \_\_\_\_\_  
 Do you exercise?    Yes   No    How often? \_\_\_\_\_

Immunizations: (Year)

Tetanus \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Measles/Mumps/Rubella \_\_\_\_\_  
 Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_ Hepatitis B \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_

Preventive Health: (Month/Year)

Last mammogram _____	Last pap smear _____
Last rectal _____	Last cholesterol _____
Last colonoscopy _____	Last stress test _____
Last prostate exam _____	Last chest x-ray _____