NORTHERN
Family Medicine
a department of Northern Regional Hospital

Account Number: ____

New Patient History Form

Name:_____Age:_____Date of Birth:____/___/_____Sex: M F
M D Y

Reason for Visit:_____

PAST MEDICAL HISTORY: Have you ever had any of the following:

Check each item	No	Yes	Check each item	No	Yes	Check each item	No	Yes
Anemia			Emphysema			Mitral valve prolapse		
Anxiety			Fibromyalgia			Osteoarthritis		
Asthma			Gallstones			Phlebitis		
Back disorder			Heart attack			Pneumonia		
Blood clot			Hepatitis			Rheumatoid arthritis		
Cancer			Hypertension			Seizure		
COPD			Kidney infection			Stomach ulcer		
Coronary artery disease			Kidney stone			Stroke		
Depression			Liver Disease			Thyroid trouble		
Diabetes			Lupus			Tuberculosis		

List Medications you are currently taking, including over-the-counter or non-prescription.

NAME	Strength	How often taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SOCIAL HISTORY

Occupation:_____ ☐ Retired ☐ Disabled ☐ Unemployed

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children:_____ Hobbies:_____

Are you ☐ Right Handed ☐ Left Handed

Are you an Athlete? ☐ No ☐ Yes – What sport(s)? _____

Level: ☐ Recreational ☐ Middle School ☐ High School ☐ College

Do you have any advanced directives? (Living Will, Health Care Power of Attorney, Do Not Resuscitate)
If yes, please specify: _____

Do you have any cultural, religious or emotional concerns in regards to your healthcare? Yes or No. If yes, please explain _____

Do you have any financial concerns in regards to your healthcare? Yes or No. If yes , please explain._____

Do you have access for adequate food/nutrition needs?_____

Do you feel that you understand the instructions that are given to you by your provider or pharmacist? Yes or No. If no, please explain_____

Are you an Organ Donor? Yes or No

Preferred Language for discussing your health care:_____

Are you now or have you ever been a victim of domestic violence/abuse? _____

Your Personal Habits: Do you….	No	Yes	Do you….	No	Yes
Regularly exercise (3-4 times weekly)			Use alcohol		
Wear auto seat belt (90% of time)			Smoke (if ever when did you stop?)		
Use illegal drugs					

Have you ever been evaluated by a Pain Management Specialist? Yes or No

Are you currently being seen by Pain Management? Yes or No. If Yes What Clinic? _____

Do you have Suicidal Thoughts or Tendencies? Yes or No

Do you have Problems Hearing? Yes or No

Do you have Problems with your Vision? Yes or No

FAMILY HISTORY: Do you have a family history of:

	No	Yes	Family Member		No	Yes	Family Member
Anesthesia Problem				High Blood Pressure			
Bleeding Problem				Osteoporosis			
Cancer (location)				Stroke			
Diabetes				Thyroid Disease			
Heart Disease				Mental Illness			
				Other:			

ALLERGIES: List any medication allergies.

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

Please check if you are allergic to: ☐ Eggs ☐ Iodine ☐ Shellfish

Please list any food allergies: _____

Your hospitalizations: ☐ None Year Hospital

Illness: (kind) _____ _____ _____

_____ _____ _____

_____ _____ _____

Surgery: (kind) _____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had a bone density test? ☐ No ☐ Yes Ifyes, when? _____

Have you ever been under the care of Pain Management? ☐ No ☐ Yes If yes, when? _____

REVIEW OF SYSTEMS: Do you have now or have you had any of the following within the past year?

	No	Yes			No	Yes	
		Now	In past			Now	In past
Fatigue				Changes in Mental Status			
Night Sweats				Seizures			
Double Vision				Joint Swelling			
Blurred Vision				Limited Movement			
Vertigo				Cold Intolerance			
Recent Head Injury				Heat Intolerance			
Chest Pain				Lymph node Enlargement or Tenderness			
Irregular Heart Beat				Frequent Illness			
Shortness of Breath				Other:			
Productive Cough				Other:			
Nausea				Are you having Pain Today? Yes or No			
Vomiting				Other:			
Difficulty Urinating				Other:			
Urine Retention				Other:			
Change in hair growth				Other:			
Sores on Skin				Other:			