Preventive Medicine

Carol J. Gardner, D.O.

New Patient Profile

First Name:_____MI:_____ Last Name: _____

Date of Birth:_____Age:_____ Sex: M ___ F_____

Address:_____

Home Phone:_____Cell Phone:_____

Email:_____

Present Health Concerns: Please list your health concern in order of priority:

Concern	Onset	Severity

What do you believe is causing your most important health concerns?_____

_____

What goals do you have for your visit today?_____

_____

Health Practitioners: Please list your current practitioners with their contact information:

	Practitioner/Physician	Office name	City/State	Phone
Referring Physician				
Primary Care				
OB/Gyn				
Specialist				
Therapist				
Other				

Please list your preferred **pharmacies** (ordered by preference)

Pharmacy	Address	Phone

Medications: please list any supplements, prescriptions or over the counter medications and you are currently taking:

Medication/Supplement	Purpose	Date started	Strength	Dosage

Past Medical History: please list your age at each event and describe:

Serious illnesses and injuries:_____
Surgeries:_____
Hospitalizations:_____

	Most recent date taken/done	Age	Results
Physical/annual exam			
Colonoscopy			
Bone scan			
EKG			
PAP/breast exam			
Mammogram			
PSA test			

Vaccinations you've had:_____
Last tetanus vaccine:_____
Flu shot? Y N

Please list known allergies and the severity of your reaction to allergens:_____
_____

Personal and Family Medical History:

Please check the box next to each condition that applies to *you* or one of your *biological family members*.

	You	Mother	Father	Mother's side	Father's side
Alcohol/drug abuse					
Allergies or hay fever					
Alzheimers or dementia					
Anemia					
Anxiety/panic attacks					
Arthritis/joint disease					
Asthma					
Cancer (type)					
COPD/Emphysema					
Depression					
Diabetes					
Eczema					
Epilepsy or seizures					
Migraines/headaches					
Heart attack					
Heart disease					
High blood pressure					
High cholesterol					
HIV/AIDs					
Liver disease/hepatitis					
Osteoporosis					
Stroke					
Thyroid disorder					
Other					

Social History: check off box that applies to you

Marital Status: ☐single ☐married ☐civil Union ☐divorced ☐other ☐significant other

Children? ☐No ☐Yes Please list ages:_____

Household: ☐alone ☐spouse/SO ☐children ☐grandchildren ☐parents

Education: ☐high School/GED ☐undergraduate college/university ☐graduate college/university

Occupation: ☐Student ☐work (full time) ☐work (part time) ☐stay at home parent ☐ unemployed ☐volunteer ☐retired ☐disability

What is your school/job and how many hours do you devote to it per week?

_____

Life now is:
☐wonderful ☐satisfactory ☐boring ☐too demanding ☐unsatisfactory

Lifestyle and Personal Habits:

What are your primary sources of stress?_____
_____

How much does stress impact your life?_____
_____

How do you manage stress?_____
_____

Are you?

	Yes	No	If no, why?
Currently Sexually active? Contraception used:			
Satisfied with your sex-life?			
Satisfied with your social life?			
Satisfied with your spiritual life?			

Do You?

	Yes	No	Elaborate
Enjoy your job?			
Exercise regularly? (If yes, what type and how often)			
Sleep soundly and wake rested?			
Smoke tobacco?			
Drink Alcohol? (If yes, how often?)			
Use recreational drugs?			
Drink caffeinated beverages?			

Diet:

Please describe foods typically eaten at each meal:

	Typical meal/foods eaten
First Meal/ Breakfast	
Lunch	
Last meal/ Dinner	
Snacks	

Do you have dietary Restrictions?_____

_____

Overview:

What else would you like us to know about you?_____

_____

_____

Signature of Patient Date