Preventive Medicine

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New Patient Profile *Date:*

First Name:_____MI:_____ Last Name: _____

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

Address (street, city, zip code):_____

Home Phone #:_____Cell Phone #:_____

Email:_____

Emergency Contact Name:_____

Contact's Phone #:_____

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

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

Drug Allergies	Reaction

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

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

	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?			

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

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	Sister	Brother	Maternal: Please indicate Grandmother, Grandfather, Aunt or Uncle.	Paternal: Please indicate Grandmother, Grandfather, Aunt or Uncle.
Alcohol/drug abuse							
Allergies or hay fever							
Alzheimers/Dementia							
Anemia							
Anxiety/panic attacks							
Arthritis/joint disease							
Asthma							
Cancer (type)							
COPD/Emphysema							
Depression							
Diabetes							
Eczema							
Epilepsy or seizures							
Migraines/headaches							
art attack							
Heart disease							
High blood pressure							
High cholesterol							
HIV/AIDs							
Liver disease/hepatitis							
Osteoporosis							
Stroke							
Thyroid disorder							
Other							

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?			

Diet:

Please describe foods typically eaten at each meal:

First Meal/ Breakfast	
Lunch	
Last meal/ Dinner	
Snacks	

Do you have dietary Restrictions?_____

_____

To Rule out Tick Borne Illness: If you are not here to rule out Tick-borne Illness please write NA (not applicable across this section)

Have you ever been bitten by a tick? Yes_____No_____ When (what year)?

On what part of your body?_____

Did you get a rash? _____

When did your symptoms begin? _____

What Year did symptoms begin? _____

Do you: (circle one)
Hunt? Yes No
Have pets? Yes No
Camp or Hike? Yes No

Live in a rural Area? Yes No

Please list all joint pains (head to toe)

_____

_____

Overview:

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

_____

_____

_____
Signature of Patient Date