NOVANT HEALTH

New Patient History

Today's Date: _____

Name: _____ **DOB:** _____ **Physician:** _____

What is the main reason for your visit to the doctor today? _____

Allergies: _____

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Heart attack or disease			Diabetes			Bleeding Disorder		
High blood pressure			High cholesterol			Blood clot		
Heart murmur			Ulcer/Reflux			Thyroid disorder		
Stroke			Gallstones			Sexually transmitted diseases		
Pneumonia			Diverticulitis			Seizures		
Rheumatic fever			Hepatitis			Transfusions		
Asthma			Tuberculosis			Cancer (type)		
Depression/Anxiety			Arthritis/Joint problems			Kidney stones		

Others: _____

Hospitalizations	Date	Physician	Hospital

Surgeries	Date	Surgeon	Hospital

Social History

Marital Status: _____ Seatbelt use: Yes ____ No ____ Number of living children: _____

Occupation: _____

Do you or have you ever used the following? Please list how much.

Tobacco: _____ Alcohol: _____ Drugs: _____

Caffeine: _____ Exercise: _____ Diet: _____

Members of Household	Age	Relationship	Health Status

NOVANT HEALTH

New Patient History

Family History (Please list any diseases such as: cancer, high blood pressure, diabetes, stroke, heart attack & age at time of attack, high cholesterol, asthma, thyroid)

Members	Age	Diseases	Deceased from	Age at Death
Mom				
Dad				
Brothers				
Sisters				

Do you now have any of the following symptoms?

	Yes	No		Yes	No		Yes	No
Skin rash			Trouble with swallowing			Painful or swollen joints		
Swollen glands			Frequent indigestion			Frequent backache		
Eye problems			Abdominal pain			Any weakness of arm or leg		
Ear problems			Vomiting blood			Frequent dizziness		
Recurring nosebleeds			Frequent constipation			Fainting spells		
Persistent hoarseness			Frequent diarrhea			Frequent headaches		
Irregular heartbeat			Change in bowel habits			Double vision		
Shortness of breath			Bloody bowel movements			Unusual worry or depression		
Wheezing			Slow urinary stream			Excessive weight gain or loss		
Coughing up blood			Frequent urination at night			Abuse from member of household		
Chest pain or pressure			Painful urination			Sexual difficulty		
Swelling of ankles or feet			Urinary leakage			Irregular periods		

(Women) Last period _____ Number of pregnancies (include miscarriages & abortions) _____

When did you last have these tests?

Mammogram _____ Pap Smear _____ Colon Test _____ Bone density test _____

Immunizations (please list the dates of your last if known)

Tetanus _____ TB test _____ Pneumonia shot _____ Hepatitis _____ Chicken pox _____ Other _____

Please list all medications you are currently taking, (include any over the counter medications, herbal medications, and vitamins):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Patient Signature or Authorized Representative: _____ Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Below For Provider Use Only

Form Review:

Date of review: _____ Time: _____ Signature of Provider: _____

Date of review: _____ Time: _____ Signature of Provider: _____

Date of review: _____ Time: _____ Signature of Provider: _____