alpinemedicalgroup

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**Name**_____**Date**_____

**Date of Birth**_____**Place of Birth**_____

**E-mail Address**_____

**Preferred Method of Communication**_____

**May we email general information about our clinic?** YES/NO

**Name of Primary Care Physician**_____

## Health History for NEW Patients

Main reason for today's visit: _____

What are your health goals for the next year? _____

Where were you receiving your care before? _____

**REVIEW OF SYMPTOMS:** Please place a mark next to any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns on the back of this form.

**General:**
__Fever/chills
__Night sweats
__Unexplained weakness
__Excessive fatigue
__Decreased activity
__Unexplained weight loss/gain
__No Problems

**Respiratory:**
__Shortness of Breath
__Cough
__Wheezing
__Loud Snoring
__Short of breath – exercise
__Short of breath – lying down
__Coughing up Blood
__Coughing up Phlegm
__No Problems

**Ear/Nose/Throat:**
__Nose Bleeds
__Nasal Congestion
__Sore Throat/Hoarseness
__Trouble Swallowing
__Hearing loss
__Ear pain
__Dental cavities
__No Problems

**Eye:**
__Eye Mattering/Discharge
__Blindness
__Blurred/Double Vision
__Glasses/Contact Lenses
__No Problems

**Neurological:**
__Leaking Urine
__Headache
__Blood in Urine
__Memory loss/confusion

**Skin:**
__Rash
__Itching
__New Change in mole
__Hair Loss/Change
__Change in nails
__No Problems

**Cardiovascular:**
__Chest Pain/Discomfort
__Heart Palpitations
__Swelling in legs/feet
__No Problems

**Gastrointestinal:**
__Nausea/Vomiting
__Diarrhea
__Blood in Stools
__Hemorrhoids
__Constipation
__Abdominal Pain
__Heartburn/Reflux
__Indigestion
__Bloating
__Loss of bowel control
__Problems eating
__Loss of appetite
__Excessive gas
__Rectal Pain
__No Problems

**Genitourinary:**
__Leaking Urine
__Blood in Urine
__Nighttime Urination
__Urinating More Often
__Discharge: Penis or Vagina
__Concerns w/Sexual Function
__Testicular Pain/lumps
__No Problems

**Musculoskeletal:**
__Back Pain
__Neck Pain
__Muscle Aches/Cramps
__Joint Pain
__Muscle Weakness
__Decreased Joint Motion
__Joint Stiffness
__No Problems

**Hematologic/Lymphatic:**
__Bruise Easily
__Bleeding Tendency
__Swollen glands
__No Problems

**Endocrine:**
__Heat Sensitivity
__Cold Sensitivity
__Excessive Hunger
__Excessive Thirst
__High/Low blood sugar
__No Problems

**Neurological:**
__Headache
__Memory loss/confusion
__Fainting
__Dizziness
__Numbness/Tingling
__Unsteady Gait
__Frequent Falls
__Tremors
__Seizures
__No Problems

**Psychiatric:**
__Anxiety/Stress/Irritability
__Sleep Problems
__Lack of Concentration
__Change in Behavior
__Change in Personality
__Anorexia
__Binging/Purging
__Lack of Joy/Feelings of Hopelessness
__Depression/Thoughts of Suicide
__No Problems

**Women Only:**
__Pre-Menstrual Symptoms
__Excessive/Irregular Bleeding
__Hot Flashes/Night Sweats
__No Problems

**Breasts:**
__Breast Lump/Pain
__Nipple Pain
__Nipple discharge
__No Problems

**MEDICATIONS.** Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room.

□ **I TAKE NO MEDICATIONS** **Please List Your PHARMACY of Choice**_____

| MEDICATION | DOSE (MG OR MCG/PILL) | HOW MANY TIMES PER DAY? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGIES.** Please list all allergies or intolerance to medications:

□ **NO KNOWN ALLERGIES**

| ALLERGIES | TYPE OF REACTION |
|---|---|
| | |
| | |
| | |

**PERSONAL MEDICAL HISTORY.** Do you have now (current) or have you had in the past any of the following conditions?

| X | CONDITION | COMMENT | X | CONDITION | COMMENT |
|---|---|---|---|---|---|
| | Alcohol/Drug Abuse | | | Cancer Prostate | |
| | Allergy/Hay Fever | | | Cancer (Other type) | |
| | Anemia | | | Cataracts | |
| | Anxiety | | | Colon Polyp | |
| | Arthritis (Rheumatoid) | | | Coronary Artery Disease/Heart Attack | |
| | Arthritis (Osteoarthritis) | | | Depression | |
| | Asthma | | | Diabetes (Adult Onset) (Type 2) | |
| | Atrial Fibrillation | | | Diabetes (Childhood Onset) (Type 1) | |
| | Bipolar Disorder | | | Diverticulosis | |
| | Bladder Problems | | | Emphysema (COPD) | |
| | Blood Clot (leg/lung) | | | Fractures (broken bones) | |
| | Blood Transfusion | | | Gallbladder Disease | |
| | Breast Condition (benign) | | | Heartburn/Reflux (GERD) | |
| | Cancer Breast | | | Glaucoma | |
| | Cancer Colon | | | Gout | |
| | Cancer Lung | | | Gyn. Conditions (Endometriosis) | |

*Personal Medical History continued*

| X | CONDITION | COMMENT | X | CONDITION | COMMENT |
|---|---|---|---|---|---|
| | Gyn. Conditions (Fibroids) | | | Prostate Enlargement/Nodules | |
| | Hepatitis – Type A/Type B/Type C | | | Seizures/Epilepsy | |
| | High Blood Pressure | | | Skin Condition (Eczema/Psoriasis) | |
| | High Cholesterol | | | Skin Cancer | |
| | Inflammatory Bowel Disease | | | Sleep Apnea | |
| | Irritable Bowel Syndrome | | | Stomach Ulcer | |
| | Kidney Disease/Failure | | | Stroke | |
| | Kidney Stones | | | Overactive Thyroid/Hyperthyroidism | |
| | Liver Disease | | | Low Thyroid/Hypothyroidism | |
| | Lupus | | | UTI | |
| | Migraine/Tension Headaches | | | Other (list) | |
| | Osteoporosis | | | Other (list) | |
| | Pancreatitis | | | Other (list) | |
| | Pneumonia | | | Other (list) | |

**SURGICAL HISTORY.** Please check off any procedures or surgeries. □ None

| X | SURGICAL PROCEDURE | YEAR | COMMENTS |
|---|---|---|---|
| | Hernia Repair | | |
| | Appendectomy (appendix removal) | | |
| | Back/Neck (Spine) Surgery | | |
| | Biopsy (Location) | | |
| | Breast Biopsy/Surgery (Right/Left/Both) | | |
| | Cataract (Right/Left/Both) | | |
| | Colonoscopy/Sigmoidoscopy | | |
| | EGD (Stomach Endoscopy) | | |
| | Gastric band/bypass (Weight Loss Surgery) | | |
| | Gallbladder Removal (Open or Laparoscopic) | | |
| | Coronary Bypass or Stent | | |
| | Heart Surgery (Other than Coronary Bypass) | | |
| | Hip Surgery (Right/Left/Both) | | |
| | Knee Surgery (Right/Left/Both) | | |
| | Hysterectomy (Total or Partial) | | |
| | Ovary Removal or Ligation (“Tubal”) | | |
| | Vasectomy | | |
| | Other (List) | | |
| | Other (List) | | |

**FAMILY HISTORY.** Please indicate which relative has had the following diseases (Parents and siblings are the most important)

**ADOPTED?** YES or NO (please circle) If yes and you do **not** know your family history, please check the box below and you may skip this section.

| X | DISEASE | RELATION | COMMENTS |
|---|---|---|---|
| | **No significant history known** | | |
| | Alcoholism/Drug abuse | | |
| | Alzheimer's Dementia | | |
| | Asthma | | |
| | Autoimmune Disease | | |
| | Bleeding or Clotting Disorder | | |
| | Cancer **TYPE:** | | |
| | Cancer **TYPE:** | | |
| | Cancer **TYPE:** | | |
| | Colon Polyp | | |
| | Coronary Artery Disease (Heart Attack, Angina) | | |
| | Depression/Suicide/Anxiety | | |
| | Diabetes (Adult Onset) (Type 2) | | |
| | Diabetes (Childhood Onset) (Type 1) | | |
| | Emphysema (COPD) | | |
| | Genetic Disorder (explain) | | |
| | Heart Failure (CHF) | | |
| | Hepatitis ( A, B, or C) | | |
| | High Blood Pressure (Hypertension) | | |
| | High Cholesterol | | |
| | Hypothyroidism/Thyroid Disease | | |
| | Kidney Disease | | |
| | Migraine Headaches | | |
| | Osteoporosis | | |
| | Stroke | | |
| | Other (please specify) | | |
| | Other (please specify) | | |
| | Other (please specify) | | |

**SOCIAL HISTORY.** Please fill out completely.

## TOBACCO USE

Smoke cigarettes: ☐ NEVER ☐ NO ☐ YES
Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Current smoker: Packs/day___ Number of years:____
Quit Date: _____
How many years did you smoke? _____
How many packs a day did you smoke? _____

## ALCOHOL USE

Do you drink alcohol? ☐ No ☐ Yes
Number of drinks per week: _____
☐ Beer ☐ Wine ☐ Liquor

## DRUG USE

Do you use recreational drugs? ☐ No ☐ Yes
Use needles to inject drugs? ☐ No ☐ Yes
Abuse Prescription drugs? ☐ No ☐ Yes

## SEXUAL ACTIVITY

Sexually involved currently: ☐ No ☐ Yes
Birth control: ☐ None ☐ Condom ☐ Pill ☐ Diaphragm
☐ Other:_____

## EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
What kind of exercise? _____
How many minutes? _____
How often?_____

## DIET

Are you following a special diet? ☐ No ☐ Yes
Type: _____
Would you like help with your diet? ☐ No ☐ Yes

## SAFETY

Do you use seatbelts consistently? ☐ Yes ☐ No
Home has a working smoke detector? ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Do you have a gun at home? ☐ Yes ☐ No

## WOMEN'S HEALTH HISTORY

Total number of pregnancies: _____
Number of births: _____
Date of last menstrual period: _____
Age at beginning of periods (menstruation):_____
Age at end of periods (menopause): _____

## EMPLOYMENT/PERSONAL

Occupation (or prior occupation):_____
☐ Retired ☐ Unemployed ☐ Leave of Absence
☐ Disabled
Employer: _____
Marital Status ☐ Single ☐ Married ☐ Divorced
☐ Partner ☐ Widowed
Spouse's/Partner's Name: _____
Number of Children & Ages: _____
Number of Grandchildren:_____
Who lives at home with you? _____

## EDUCATION

High School Graduate? ☐ Yes ☐ No ☐ GED
Highest Educational Level: _____

## IMMUNIZATIONS

Check this box if you don't know the information ☐
Please check off any vaccinations. Add year, if known.
Tetanus (Td)_____
Pneumovax (pneumonia) _____
Varicella (Chicken Pox) shot or illness _____
Hepatitis A _____
Hepatitis B _____
MMR _____
Meningitis _____
Zostavax (shingles) _____
HPV _____
Influenza (flu shot)_____

## HEALTH MAINTENANCE SCREENING TESTS

Mammogram (Women Only): Date _____
Pap Smear (Women Only): Date _____
Bone Density Test (Women Only): Date _____
Lipid (cholesterol) Screening: Date _____
Colonoscopy or Sigmoidoscopy: Date _____

**Thank you for taking the time to fill out this important health documentation.**