NEW PATIENT COMPREHENSIVE ASSESSMENT

CONFIDENTIAL

Patient Name: ______________________________ Today's Date: ______________

Age: ________ Date of Birth: ______________ Date of last physical examination: ________________

Phone: ____________ Do you give us permission to leave messages regarding appointments, lab results, etc.? ☐ YES ☐ NO

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details and exact dates. Please complete all pages. **Thank you!**

We recommend and encourage the use of our patient portal, *FollowMyHealth* as a preferred means of communication with your provider.

MEDICATIONS: Prescriptions and non-prescription medications, vitamins, birth control, herbs, home remedies.

☐ I take no regular medications

Name of Medication | Dose, Times/Day	Name of Medication | Dose, Times/Day

PHARMACY: ______________________ Address: ______________ Phone #: __________

ALLERGIES: To medications or substances ☐ I have no known allergies

Allergy	Reaction or Side Effect

PREVENTATIVE SCREENINGS

Date of last colonoscopy: __________ Doctor's Name: __________ Result: ______________

Eye Exam: ☐ Glaucoma Screen ☐ Dilated Retinal Exam ~ Exam Date: ________ Doctor's Name: __________

IMMUNIZATIONS: Please list your most recent immunizations; include your best estimate of the month and year.

☐ Flu ______________

☐ Shingles ______________

☐ Varicella (Chickenpox) ________

☐ Pneumovax (Pneumonia) ________

☐ Hepatitis A ______________

☐ Hepatitis B ______________

☐ Tetanus (Td/Tdap) ________

☐ MMR ______________
(Measles, Mumps, Rubella)

☐ Prevnar 13 ______________

☐ HPV ______________

☐ Meningitis ______________

☐ Other ______________

Name: ______________________________ DOB: _______________

SYMPTOMS: Please check symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pains, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Other
- Date of last menstrual period ________
- Date of last Pap Smear ____________
- Date of last OBGYN visit ___________
- Date of last Mammogram __________

Result _______________

CONDITIONS: Please check conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthmas
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEN'S HEALTH HISTORY (For Men Over 50 years old)

When was your last prostate exam? __________ Results: ______________________________

Have you had any prostate problems? ☐ NO ☐ YES: please specify: ______________________

Did you have any treatment for your prostate problems? ☐ NO ☐ YES: ___________________

Do you have concerns about erectile dysfunction? ☐ NO ☐ YES

Name: ______________________________ DOB: _______________

WOMEN GYNECOLOGIC HISTORY

Pregnancies: __________ # Deliveries: ____________ # Abortions: ____________ # Miscarriages: ____________

Age of 1st period: ________ 1st day, last period: ________ Frequency of periods: _______ Length of each: ________

Do you have any concerns about your periods? ☐ NO ☐ YES: ______________________________________

If you have stopped having periods, please specify age when you reached menopause: __________________________

SOCIAL HISTORY

TOBACCO USE

Please check one:

☐ I have never smoked

☐ I have quit smoking. Quit Date: _____________

☐ I currently smoke: _____ pack(s)/day, # of years____

Other Tobacco:

☐ Tobacco ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you currently trying to quit? ☐ YES ☐ NO

DRUG USE

Do you use any recreational drugs? ☐ YES ☐ NO

Have you ever used needles? ☐ YES ☐ NO

ALCOHOL USE

Do you drink alcohol?

☐ Never ☐ Occasionally ☐ Regularly

Average # of drinks/week:

_____ 5oz glass of wine

_____ 12 oz. beer

_____ 1.5 oz. shots of hard liquor

Is alcohol use a concern for you or others? ☐ YES ☐ NO

CONTRACEPTION AND PROTECTION

Birth control method: __________________ ☐ None

If sexually active, do you practice safe sex?

☐ YES ☐ NO ☐ N/A

SEXUAL ACTIVITY

Sexually Active: ☐ YES ☐ NO ☐ N/A

Current sex partner(s) is/are: ☐ Male ☐ Female

Have you ever had any sexually transmitted diseases (STDs)? ☐ YES ☐ NO

Type: ________________ Date: _____________

Type: ________________ Date: _____________

Are you interested in being screened for sexually transmitted diseases? ☐ YES ☐ NO

Other Concerns: _____________________________

FALLS

Have you recently had any falls? ☐ YES ☐ NO

SAFETY

Do you use seatbelts consistently? ☐ YES ☐ NO

Do you use a bike regularly? ☐ YES ☐ NO

Is violence at home a concern for you? ☐ YES ☐ NO

Are you currently in a relationship? ☐ YES ☐ NO

If yes, do you feel safe in the relationship? ☐ YES ☐ NO

Do you have a gun in your home? ☐ YES ☐ NO

Other concerns: ______________________________

EMOTIONS

Please rate each question, using the following scale:

0 = Not at all 1 = Several days

2 = More than half the days 3 = Nearly every day

Over the past two weeks, how often have you been bother by any of the following problems?

- Little interest or pleasure in doing things? ________
- Feeling down, depressed or hopeless? __________

EXERCISE

How active are you?

☐ I get a cardiovascular work-out 3 or more times/week

☐ I walk daily but do not work out

☐ I exercise or walk less than 3 times/week

☐ I am not generally active

☐ Other: ______________________________

MARITAL STATUS

☐ Single ☐ Engaged ☐ Married _____years

☐ Separated ☐ Divorced ☐ Widow

☐ Lives with _______________

Number of children: _________

Who lives at home with you? ____________________

EDUCATION LEVEL COMPLETED

☐ Grade School ☐ High School ☐ College

☐ Graduate School ☐ Other: _______________

Occupation: ______________________________

How long? ______________________________

Name: ______________________________ DOB: _______________

FAMILY HISTORY: Fill in health information about your immediate family

Relation	Age	State of Health	Condition(s)	Please check if your blood relatives had any of the following:		
					Disease	Relationship to you
Father				☐	Arthritis, Gout	
				☐	Asthma, Hay Fever	
Mother				☐	Cancer	
				☐	Chemical Dependency	
Brother(s)				☐	Diabetes	
				☐	Heart Disease, Strokes	
				☐	High Blood Pressure	
Sister(s)				☐	Kidney Disease	
				☐	Tuberculosis	
				☐	Other	

If deceased: Father's age of death: _________ Cause: ______________________________

Mother's age of death: ________ Cause: ______________________________

HOSPITALIZATIONS/ SURGERIES: ☐ I have had no prior surgery

Date	Hospital	Reason for Hospitalization/Surgery	Outcome

By signing this, I hereby certify that to the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

Patient Signature: ____ Date: ______________________

Reviewed by: ____ Date: ______________________

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