UB|MD INTERNAL MEDICINE

NEW PATIENT HEALTH HISTORY

Please **take time** *to complete the following information for your medical chart. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.*
Please address EVERY section

PATIENT NAME	**BIRTH DATE** / /	**TODAY'S DATE** / /

REASONS FOR YOUR VISIT *(list current symptoms)*

1.	3.
2.	4.

PHARMACY INFORMATION

Please provide accurate pharmacy information so that we can fill/refill medications you may need.

Local Pharmacy Name: _____

Pharmacy Street Address: _____

_____

Pharmacy Phone #: _____

Do you use a **Mail Order Pharmacy**? Y / N

If yes, **Name of Mail Order Pharmacy**: _____

MEDICATIONS

Include all current medications including prescriptions, infusions, and over-the-counter herbal/vitamins/supplements *IF NOT ON ANY MEDICATIONS PLEASE CHECK "NONE"*

NAME OF MEDICATION	DOSAGE	HOW OFTEN IS IT TAKEN?	REASON FOR MEDICATION	PHYSICIAN PRESCRIBING THIS MEDICATION
EX: Aspirin	**81 MG**	**Daily, Twice a day, Bedtime etc.**	**Stroke Prevention**	**Dr John Doe**
☐ **NONE**				

PATIENT NAME	BIRTH DATE / /

ALLERGIES *Include medications, food, latex, adhesive, chemicals, insects, etc. IF NO KNOWN ALLERGIES PLEASE CHECK "NONE"*

ITEM	TYPE OF REACTION
☐ **NONE**	

MEDICAL HISTORY

Condition	Date-of-onset	Hospitalized	Specialist
☐ **NONE**		(circle)	
1.		Y / N	
2.		Y / N	
3.		Y / N	
4.		Y / N	
5.		Y / N	
6.		Y / N.	
7.		Y / N	
8.		Y / N	

Please use a separate sheet of paper to list any others

SURGICAL HISTORY Please list ALL *Surgeries- Procedures- Hospitalizations* ~ ***INCLUDE DATE*** ~

Procedure/Reason/Diagnosis	Date	Procedure/Reason/Diagnosis	Date
☐ **NONE**		5.	
1.		6.	
2.		7.	
3.		8.	
4.		Please use a separate sheet of paper to list any others	

PATIENT NAME	BIRTH DATE / /

IMMEDIATE FAMILY HISTORY

(For example, diabetes, high blood pressure, heart disease, stroke, cancer, etc.)

Please complete the following information on your biologic relatives

IF DECEASED, PLEASE INCLUDE AGE AT TIME OF DEATH

Family Members	Living	Deceased	Age	Sex	Chronic Condition(s) - If deceased, Cause of Death and age at time of death
Father	☐	☐			
Mother	☐	☐			
Brothers or Sisters:					
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
Children:					
	☐	☐		M F	
	☐	☐		M F	
	☐	☐		M F	
Other (Uncles, Aunts, etc.):					
	☐	☐		M F	
	☐	☐		M F	

PATIENT NAME	BIRTH DATE / /

PERSONAL HISTORY

Please complete the following information about yourself.

Current occupation: _____

Have you ever worked in a job where you were exposed to hazardous environment or chemicals? Y / N

Education completed:

☐ Grade: _____ ☐ High School ☐ College: _____ years, degree/major _____

☐ Post-graduate:_____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: _____ What are their ages? _____

Personal habits: *(please check all that apply)*

☐ Currently use tobacco/nicotine products: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco

☐ Other Amount / day: _____ Years: _____

☐ Former smoker: Amount / day: _____ Years: _____ Quit Date: _____

☐ Never smoked

☐ Consume alcohol: Y / N Type: _____

Amount / day: _____

☐ Use recreational drugs: Y / N Type: _____

Frequency: _____

☐ Exercise regularly: Y / N Type: _____

Frequency: _____

Living Situation/Circumstances:

Do you live alone? Y / N If No, with whom do you live? _____

Do you have a caregiver? Y / N If Yes, whom: _____

Are you a caregiver? Y / N If Yes, for whom: _____

Do you have a good support network of family/friends? Y / N If No, please explain:

_____

Do you have any communication needs due to hearing, seeing or other issues such as memory or difficulty understanding or reading? Y / N If Yes, please explain: _____

Do you have any cultural needs or beliefs that affect your health care needs? If Yes, please explain:

_____

Do you have a health care proxy? Y / N / Not Sure

Do you have an advanced care directives? Y / N / Not Sure

Would you like to discuss planning Advance Directives at your visit? Y / N

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____

UB|MD INTERNAL MEDICINE

PRIMARY CARE ONLY

PATIENT NAME	BIRTH DATE / /

IMMUNIZATIONS & PREVENTIVE SERVICES *Check all that apply and PROVIDE DATE received*

PLEASE NOTE: All patients under 18 must have vaccine records either attached or transferred by previous MD

	DATE/Yr.
☐ **NONE**	
☐ Flu vaccine	_____
☐ MMR	_____
☐ Tetanus	_____
☐ Prevnar vaccine	_____
☐ Pneumovax 23 vaccine	_____
☐ Hepatitis B vaccines	_____
☐ HPV vaccine	_____
☐ Hepatitis A vaccines	_____
☐ Zoster Vaccine	_____

	DATE/Yr.
☐ Last bloodwork	_____
Where:	_____
☐ HIV Testing	_____
☐ Hepatitis C Testing	_____
☐ STD Testing	_____
☐ Hearing test	_____
☐ Eye exam	_____
☐ Dental exam	_____
☐ OTHER	_____
☐ OTHER	_____

	DATE/Yr.
☐ PAP smear	_____
☐ Mammogram	_____
Where:	_____
☐ Bone density test	_____
☐ Colonoscopy	_____
Where:	_____
Who:	_____
☐ Abdominal Aortic Aneurysm Screening	
Date/Yr:	_____
Where:	_____

PERSONAL HABITS *Please complete the following information about yourself.*

Do you wear a seatbelt? Always / Occasionally / Never

Do you talk/text on phone while driving? Y / N

Do you have a smoke detector? Y / N

Do you have a carbon monoxide detector? Y / N

Do you have any unsecured guns in the home? Y / N

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

GOAL SETTING *Please complete the following information about yourself.*

What are your healthcare goals for this year? (Examples include: exercise 3 days per week; be able to kneel down and play with my grandchildren.) _____

How do you plan to accomplish these goals? _____

What are the barriers, if any? (Examples include lack of healthy food, knowledge, lack of outside exercise or play time, no safe outside environment, family distractors, genetics)

_____

_____

PHQ-2 *Please complete the following information about yourself.*

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1) Little interest or pleasure in doing things: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

2) Feeling down, depressed, or hopeless: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____