UB|MD INTERNAL MEDICINE PRIMARY & SPECIALTY CARE

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

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? _____

☐ ☐ ☐ Hearing test ☐ ☐

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

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

☐ Vape ☐ 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: _____

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

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

	DATE/YEAR		DATE/YEAR		DATE/YEAR
☐ Flu	_____	☐ HIV Testing	_____	☐ Pap smear	_____
☐ MMR	_____	☐ Hepatitis C Testing	_____	☐ Mammogram	_____
☐ Tetanus	_____	☐ STD Testing	_____	Where:_____	
☐ Prevnar	_____	☐ Hearing Test	_____	☐ Bone Density	_____
☐ Pneumovax 23	_____	☐ Eye Exam	_____	☐ Colonoscopy	_____
☐ Hepatitis A	_____	☐ Dental Exam	_____	Where:_____	
☐ Hepatitis B	_____	☐ Recent Blood Work		☐ Abdominal Aortic Aneurysm Screening	
☐ HPV	_____	Where_____		Date/Year:_____	
☐ Covid	_____			Where:_____	