

Original Date:

Dates Revised:

# SWACK MEDICAL ASSOCIATES NEW PATIENT HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<b>Previous or referring doctor:</b>	<b>Date of last physical exam:</b>	

## PERSONAL HEALTH HISTORY

<b>Childhood illness:</b>	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
<b>Immunizations and dates:</b>	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed

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### Surgeries

Year	Reason	Hospital

### Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?		
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No

*Please turn to next page*

**FAMILY HEALTH HISTORY**

AGE	SIGNIFICANT HEALTH PROBLEMS	AGE	SIGNIFICANT HEALTH PROBLEMS
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<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M		<b>Grandmother</b>		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		<b>Grandfather</b>		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		<b>Grandmother</b>		
	<input type="checkbox"/> F		<i>Paternal</i>		
	<input type="checkbox"/> M		<b>Grandfather</b>		
	<input type="checkbox"/> F		<i>Paternal</i>		

### MENTAL HEALTH

Is depression or anxiety a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have crying spells?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have thoughts of hurting yourself or anyone else?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty sleeping at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies?      Number of live births?		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any abnormal mammograms?	Yes	No
Any history of abnormal pap smear?	Yes	No
Date of last pap and rectal exam?		

### MEN ONLY

Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

### OTHER PREVENTIVE SCREENINGS

Check if you have had either of the following, and the date it was done:		
<input type="checkbox"/> Colonoscopy		
<input type="checkbox"/> DEXA		