MEMORIAL HERMANN
Executive Health

## NEW PATIENT HISTORY

Name:_____Date of Birth:_____ Today's Date:_____
Primary reason for today's visit:_____
_____
Current Primary Care Physician: _____
Specialist: (please list all) _____
_____

***Past Medical History:***

List all Medical Conditions/Diagnoses and year diagnosed by physician including any infectious diseases:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List all Hospitalizations for Medical/ Surgical procedures:

(i.e. Colonoscopy, coronary catheterization, or etc.) Please specify with dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List all Special Testing (exercise stress testing, etc.)/Radiology (MRI, CT Scan, bone density, etc.)

1. _____
2. _____
3. _____
6. _____
7. _____
8. _____

***Women and Gynecological History: (Circle Y or N)***

Do you still have monthly menstrual periods? Y N
Age periods begun: _____
Number of live births: _____
Have you had a Hysterectomy? Y N
Have you had any nipple discharge? Y N
Do you take birth control now? Y N
Mammogram Y N Date: _____

Date of last period: _____ Normal Y N
Do you bleed between periods? Y N
Have you had any miscarriages? Y N #_____
Have you had any abortions? Y N #_____
Have you ever had a breast lump? Y N
Did you take birth control previously? Y N
Last Pap Smear? Date_____

***Immunizations:*** *Bring yellow card if available or any vaccine records*

| | | | | | |
|---|---|---|---|---|---|
| Flu Vaccine | Y N | Date_____ | Tetanus Vaccine | Y N | Date_____ |
| Hepatitis A | Y N | Date(s)_____ | Hepatitis B | Y N | Date(s)_____ |
| Gardasil | Y N | Date(s)_____ | Polio | Y N | Date_____ |
| Pneumovax | Y N | Date_____ | Zostavax (Shingles) | Y N | Date_____ |

***Family History:***

Biological Parents:
Mother: Age____ Current Diagnoses _____ Deceased Y N Year: _____
Father: Age____ Current Diagnosis _____ Deceased Y N Year: _____

*How many siblings:*
Brother: #_____ Sister #:_____

*Please circle which relative for each disease:* (M) *Mother, (F) Father, (B) Brother, (S) Sister*

| | | |
|---|---|---|
| General: | Alcoholism: M F B S<br>Arthritis: M F B S | Glaucoma: M F B S |
| Cardiovascular: | Congestive Heart Failure: M F B S<br>Cholesterol: M F B S<br>Pacemaker: M F B S | High Blood Pressure: M F B S<br>Heart Disease M F B S |
| Neurological: | Blood Disorder: M F B S<br>Epilepsy: M F B S | Alzheimer's: M F B S<br>Stroke: M F B S |
| Endocrine: | Diabetes: M F B S<br>Thyroid Disease: M F B S | Gout: M F B S |
| Pulmonary: | Lung Disease: M F B S<br>COPD: M F B S | Asthma: M F B S<br>Emphysema: M F B S |
| Gastrointestinal: | Pancreatitis: M F B S | Hepatitis: M F B S |
| Psychiatric: | Schizophrenia: M F B S | Anxiety: M F B S |
| Cancer (any type): | _____<br>_____ | _____<br>_____ |

***Social History:***

Married: Y N # of years: _____ (previous marriage(s)) ____ divorced _____ widowed ____
Education: H.S. College Degree(s)_____
Spouses name: _____ # of children:_____ ages: _____
Who lives at home with you? _____
Leisure activities, groups, hobbies, volunteer work, recent travel, etc.: _____
_____
Occupation: _____

**Health Issues/Risk Factors:**

Advanced Directive Y N, (i.e. living willing)
Tobacco Use: Never Y N If, so how long did you smoke? _____years _____quit
How many cigarettes per day? _____ Smokeless Tobacco? Y N Pipe?____ Cigar?_____
Alcohol Use: Beer Wine Liquor # of drinks per day_____ per week_____
Drug Use: Marijuana Y N Other drugs _____ Use needles? Y N Current or Past
Caffeine Use: Y N Type:_____ How many per day?_____
Sexual Activity: Currently Active Y N # of Partners_____ Birth Control Method_____
Exercise: What type of exercise?_____ # of times per week?_____ How long?_____
Sleep: How many hours of continuous restorative or restful sleep per night? _____

***Stress Level: (1 being lowest – 10 being highest)***

What is your stress level on a scale of 1-10? ____ Floss daily? Y N # times weekly?____
Sun Exposure daily: Y N Wear seatbelt: Always Most of the time Occasionally

***Allergies to Medication Y N_____ Pollens/food Y N_____***

***MEDICATIONS:*** **(Please list all current medications and Vitamins/Supplements)**
****(Please circle "NONE" if you're currently not taking any Vitamins/Supplements)***
**NONE**

What pharmacy are you currently using?_____

| *Name of medication* | *Strength* | *Dosage or number of pills* | *Number times per day* | *Prescribing Physician* | *How long on medication* |
|---|---|---|---|---|---|
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***Vitamins/Supplements:***
****(Please circle "NONE" if you're currently not taking any Vitamins/Supplements)***
***NONE***

| *Name of Vitamin/Supplement* | *Strength* | *Dosage or number of pills* | *Number of times per day* | *How long on vitamin/supplements* |
|---|---|---|---|---|
| | | | | |
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