EL RIO Health

Adult New Patient Information Form

(Please complete and bring to your first appointment.)

Last Name:_____**First Name:** _____

Birth date: _____

Allergies: List all allergies to drugs, foods, plants and other substances. Tell us what happens to you.

_____ _____

_____ _____

Medications: Bring in all bottles of medicines you take, including ones that do not need a prescription, OR list the name, the dose of the medicine, how many you take and when you take it.

Medicines, Vitamins and Herbs	Dose	How many	When

Immunizations: Please bring in your shot records or fill in the approximate date below.
(MA document in immunization template under historical)

Hepatitis A _____
Hepatitis B _____
Flu _____

MMR _____
Pneumonia _____
Tetanus (Td) _____

HPV (Gardasil) _____
Tetanus with whooping cough (Tdap) _____
Zostavax (Shingles) _____

Past Medical History: Please circle any of the health problems that you have had listed below?

Arthritis—what type? _____ Cancer—what type?_____

Diabetes
Heart Disease
High Blood Pressure
High Cholesterol

Kidney Diseases
Liver Disease
Thyroid
Back Problems

Depression
Anxiety
Bipolar Disorder
Schizophrenia

Other health problems:

_____

_____

_____

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Surgeries or pregnancies: (MA-document in Med/surg/interim hx)

Surgery or Pregnancy	Date	Surgery or Pregnancy	Date

Family History: Please list any major illness, if deceased please write at what age.

Mother - _____

Father - _____

Brother(s) - _____

Sister(s) - _____

Social History:

Do you use tobacco?

No

Yes How many cigarettes per day? _____ Age started? _____

I used to How many did you smoke each day?___ Age started?____ Age quit?____

Alcohol

No, never

Yes Type of alcohol? _____ How many drinks in a week?___

I used to Year you quit? _____

What is the highest grade in school that you completed? _____

What job do you have? _____

Are you: Single Married Partnered Divorced Widow/Widower

Do you have children? _____

Who lives with you? _____

Have you ever had the tests listed below? (MA-Add approximate date into Health Maintenance care guideline)

Colonoscopy (Colon Cancer Screening) Year:_____ Where: _____

Pap Smear (Cervical Cancer Screening) Year:_____ Where: _____

Mammogram (Breast Cancer Screening) Year:_____ Where: _____

DEXA Scan (Osteoporosis Screening) Year:_____ Where: _____

For people with diabetes: (MA- Add approximate dates to Diabetes care guideline)

Have you seen an eye specialist for a Diabetes Eye Exam? **No** **Yes**: Year? _____

Have you seen a foot doctor for a Diabetic Foot Exam? **No** **Yes**: Year? _____