New Pueblo Medicine
Your Physician Team for Life

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Health History

Patient Name: _____ Date: _____

General History

How long have you lived in Arizona? _____ Did you move here for health reasons? _____

Where did you live before? _____ How long? _____

Your occupation: _____ How long? _____

What is your blood pressure: Systolic (top number) _____ Diastolic (bottom number) _____

If you do not know your blood pressure, check the box that best describes it: ❒ High ❒ Normal ❒ Low ❒Not sure

Do you have an elevated cholesterol level? ❒ Yes ❒ No ❒ Not sure

Do you smoke? ❒ Yes ❒ No If yes, how many packs per day? _____ For how many years? _____

Do you have a Living Will? ❒ Yes ❒ No

Health History

Do you have, or has a doctor ever told you that you have, any of the following conditions:

- ❒ Alcohol problems
- ❒ Arthritis/rheumatism
- ❒ Cancer (explain below)
- ❒ Congestive heart failure
- ❒ Diabetes II (non-insulin dependent)
- ❒ Epilepsy
- ❒ High cholesterol
- ❒ Liver trouble
- ❒ Stroke
- ❒ Allergies
- ❒ Asthma
- ❒ Chronic back pain
- ❒ Deafness
- ❒ Drug abuse
- ❒ Glaucoma
- ❒ Hypertension/high blood pressure
- ❒ Mental illness
- ❒ Ulcer/intestinal bleeding
- ❒ Anxiety/panic disorders
- ❒ Blindness
- ❒ Colon polyps
- ❒ Diabetes I (insulin dependent)
- ❒ Emphysema
- ❒ HIV/AIDS
- ❒ Kidney stones or disease
- ❒ Sexual problems
- ❒ Valley Fever

❒ Other: _____

_____

Hospitalizations & Surgeries

Please list hospitalizations and surgeries you've had in the last 10 years:

Date	*Name of facility*	*City/State*	*Diagnosis/Outcome*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

❒ Yes ❒ No Have you ever been advised to have a surgical operation that you have NOT undergone?
If yes, please explain: _____

❒ Yes ❒ No Have you ever had a blood transfusion? If yes, approximate date: _____

❒ Yes ❒ No Have you ever been turned down for a blood donation? If yes, please explain: _____
_____

❒ Yes ❒ No Have you ever been refused health insurance? If yes, please explain: _____
_____

Emergency Room & Urgent Care Visits

Please list visits to a hospital emergency room or urgent care facility in the last two years:

Date	*Name of facility*	*City/State*	*Diagnosis/Outcome*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunizations & Vaccinations

Please check those immunizations and vaccines you have received:

❒ MMR (measles, mumps, rubella)	Date: _____	❒ Polio	Date: _____
❒ Diphtheria-Tetanus	Date: _____	❒ Tetanus (most recent)	Date: _____
❒ Hepatitis A series	Date: _____	❒ Pneumonia vaccine	Date: _____
❒ Flu (most recent)	Date: _____	❒ Hepatitis B series	Date: _____
❒ Shingles	Date: _____	❒ Other _____	Date: _____

Family History

Has any member of your family (father, mother, siblings, grandparents) had any of the following:

- ❒ Alcohol problems
- ❒ Blindness
- ❒ Colon cancer
- ❒ Diabetes I
- ❒ Glaucoma
- ❒ Hypertension
- ❒ Ovarian cancer
- ❒ Other _____
- ❒ Arthritis/rheumatism
- ❒ Breast cancer
- ❒ Colon polyps
- ❒ Diabetes II
- ❒ Heart disease
- ❒ Kidney stones
- ❒ Prostate cancer
- ❒ Other _____
- ❒ Asthma
- ❒ Child abuse
- ❒ Deafness
- ❒ Drug abuse
- ❒ High cholesterol
- ❒ Mental illness
- ❒ Stroke
- ❒ Other _____

Family Members

Relation:	**Age:**	**State of health:**	**If deceased, cause of death:**
Father:	____	_____	_____
Mother:	____	_____	_____
Siblings:			
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
Your spouse:	____	_____	_____
Your children:			
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Women Only

Age when you began to menstruate (have periods): _____

Number of days your periods last: _____ Date of your last period: _____

Number of pregnancies: _____ Number of miscarriages/abortions: _____

Your age at first pregnancy: _____ Are you pregnant? ❒ Yes ❒ No

Date of your last pelvic exam and PAP test: _____ Are you using birth control? ❒ Yes ❒ No

If yes, type of birth control: _____

Please check if you have any of the following:

❒ Irregular periods ❒ Severe cramps ❒ Bleeding between periods

❒ Recurrent vaginal infections ❒ Pain or bleeding during intercourse ❒ Sexually transmitted disease

Please check the correct response:

Do you have a family history of breast cancer? ❒ Yes ❒ No

Do you perform regular breast self-examination? ❒ Yes ❒ No Date of last mammogram: _____

Have you had any female (Ob/Gyn) surgery? ❒ Yes ❒ No If so, type of surgery: _____

Are you satisfied with your sexual relationship(s)? ❒ Yes ❒ No

Do you have any problems or questions about sex ❒ Yes ❒ No
that you would like to discuss with your physician?

Men Only

When was your last rectal/prostate examination? ❒ Less than 1 year ago ❒More than one year ago ❒Never had one

Do you have any of the following problems?

❒ Yes ❒ No Pain or lump in testicles

❒ Yes ❒ No Difficulty with erection

❒ Yes ❒ No Weak or slow stream urine

❒ Yes ❒ No Discharge from penis

❒ Yes ❒ No Sexually transmitted disease

❒ Yes ❒ No Other: _____

Additional Questions

Please list any questions you'd like to discuss with your physician during your first visit:

_____

_____

_____