Main Line Family Practice **New Patient Form** **Date:_____**

Patient Name: _____ DOB: ___/___/____ Female☐ Male ☐

Pharmacy: _____address:_____ zip code:_____ phone:_____

Office Use BP: ____/_____ R/L arm TEMP:_____ RESP_____ Pulse_____ O2 %_____ W: _____ H:_____
MA Initials:

Today's visit: Concern/ Problems: _____ _____

Female patient's Last Menstrual Period: _____

Medication/ Vitamins: name with strength, # times/ day

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

Allergies (and reaction):**YES/NO** (if yes please list)_____

Current Medical Problems (e.g., high blood pressure)	Past Medical Problems (e.g., heart attack)

Behavioral Health Issues such as anxiety, depression: YES/NO (if yes please list) _____

Cancer: YES/NO (if yes please list)_____

Hospitalizations:_____

Past Surgeries with dates:

_____

_____

List of Specialists: please list

_____

_____

Patient name:_____ **Date:**_____

For Women: Gynecologic History

History of Abnormal pap ☐no ☐yes approximate date(s):_____

Age at first menstruation: ____

Menstrual cycle: how many days apart: _____ how many days long:_____

Do you have any clotting/heavy bleeding with menstruation: (please explain) _____

Menopause: ☐no ☐yes, last menstruation (age) _____

Pregnancies: ☐no ☐yes, number: ___ Total Births: ____ Full term: _____ Preterm: _____

Vaginal birth(s) number: ____ C-section(s)number: _____

Miscarriages ☐no ☐yes, number: ___ Abortion ☐no ☐yes, number: ___

Birth control pill: ☐no ☐yes, how many years:_____

IUD: ☐no ☐yes Depo-Provera /Nexplanon/ Nuva-Ring /Ortha-Evra Patch: ☐no ☐yes

Other hormone therapy☐no ☐yes

History of HPV/ Herpes/ Gonorrhea / Chlamydia/ Syphilis

Colposcopy ☐no ☐yes

D&C in the past? ☐no ☐yes

Uterine abnormalities?(Fibroids, other) ☐no ☐yes, if yes explain _____

Uterine ablation ☐no ☐yes Other female surgeries ☐no ☐yes _____

Social History:

Tobacco use: ☐Never ☐former Year Quit:_____☐current smoker Packs per day/week, years of smoking_____

Alcohol ☐no ☐yes, type of alcohol _____ # drinks/day _____

Recreational Drug use ☐no ☐yes, what kind of drugs and how often used: _____

Caffeinated drink (coffee, tea, soda): ☐no ☐yes, cups a day:_____

Describe your diet: _____

Occupation_____full-time/ part-time / Retired/Homemaker/ Student

Married Single Separated Divorced Widowed

Children: ☐ no ☐yes, # of girls:_____ # of boys: _____

Exercise ☐no ☐yes, # days/week____ what kind of exercise _____

Stress level: ☐high ☐moderate ☐low

Faith important: ☐no ☐yes

Sexually active: ☐no ☐yes men / women / both (please circle what applies)

Protection from sexually transmitted diseases: condom use: ☐no ☐yes

Health Maintenance: Please fill in date when last performed:

Colonoscopy	Cholesterol blood work	Dental Exam
Mammogram	Pap	Breast Exam
Eye Exam	Skin Check	Prostate Exam
Hearing Exam	Foot Exam	Bone Density

Patient name:_____ Date:_____

Family History:

Number of sisters:_____ Number of brothers:_____

Check box if family member has the particular health condition and list age when diagnosed:

	Father	Mother	Sister(s)	Brother(s)	Maternal grand mom	Maternal grand dad	Paternal grand mom	Paternal grand dad
Alive or Deceased? Age								
High blood pressure								
Arrhythmias								
Heart Attack								
Heart disease								
Heart valve disorder								
Stroke								
High cholesterol								
Diabetes								
Thyroid disorder								
Osteoporosis								
Asthma								
Reflux								
Liver disease								
Kidney disease								
Migraines								
Seizures								
Parkinson's								
Gout								
Glaucoma								
Anxiety								
Depression								
Cancer (type)								

Additional health problems (relative and problem):_____

_____

Dates of Most Recent Immunizations:

Tetanus (TDaP or TD)	Flu	Gardasil (HPV)
Shingrix	Pneumovax 23	Prevnar 13
Meningitis	Hepatitis B	Hepatitis A
Zostavax		

Patient Reviewed signature:_____ Date:_____

MD signature: _____ Date: _____