NEW PATIENT HEALTH INFORMATION

INNOVATIVE PRIMARY CARE

Name:	Date of Birth:	Today's Date:

Prescriptions, Over the Counter Medications, and Supplements

Include name, strength, number of pills and how often taken. Example: Ibuprofen, 200mg, 2 tablets, 2 times a day

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Medical History (previous health problems)

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Drug Allergies or Intolerances: Yes / No

Include medications you have tried in the past, which did not work for you.
Example: Lisinopril: did not help lower blood pressure.

1.	Reaction:	5.	Reaction:
2.	Reaction:	6.	Reaction:
3.	Reaction:	7.	Reaction:
4.	Reaction:	8.	Reaction:

Surgical History

Please also list any implants you may have had, such as pins, plates, stents, pacemakers, augmentations.

1.	5.
2.	6.
3.	7.
4.	8.

Hospitalizations

Please include the name of the hospital, reason and duration of stay.

1.	5.
2.	6.
3.	7.
4.	8.

Family History

Member	Living or Deceased	Year Born	Age	Illness
Mother				
Father				
Brothers				
Sisters				
Paternal Grandfather				

-more on reverse-

NEW PATIENT HEALTH INFORMATION

Name:	Today's Date:

Family History

Member	Living or Deceased	Year Born	Age	Illness
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Other common family health problems:				

Social History

Do you have current or history of any recreational drug use? Yes/No If yes, please provide details.
Do you exercise? Yes/No If yes, what kind and how often?
Activity level (circle one): Sedentary Extremely Inactive Moderately Active Active Very Active
Do you drink caffeine? Yes/No If yes, which drinks and how much per day?
Tobacco use? Yes/No If yes, what type? Quantity/Frequency? # of years?
Alcohol use? Yes/No If yes, please provide details:
Birthplace?
Have you traveled outside of the U.S.? Yes/No If yes, where?
Marital Status? Single Married Divorced Separated Widowed Partner
Occupation? Occupational exposure that could affect your health?
Do you have smoke detectors in your home? Yes/No

Female Health History

Last Menstrual Period:	History of Abnormal Periods: Yes / No
Last PAP Smear:	History of Abnormal PAP: Yes / No When?
Last Mammogram:	Number of Pregnancies:
Last Bone Density Scan (DEXA):	Number of Births:
Contraception used:	Cervical Procedures: Yes / No

General Health History

Last Colonoscopy and Dr. Name:	Last Test for Hidden Blood in Stool:
Last Dental Exam and Dr. Name:	Last ECHO:
Last Eye Exam and Dr. Name:	Last EKG:
Last Physical:	Last Foot Exam:

Vaccine History

Last Tetanus: Did the Tetanus vaccine include Whooping Cough/Pertussis: Yes / No	
Last Pneumovax:	Last Prevnar 13:
Last Flu Vaccine:	Last TB Test:
Last Shingles Vaccine:	Last Tdap:
Please list names and dates of any other vaccines you may have had (e.g. Hepatitis B):	
Other information?	

2915 E. Baseline Road, Ste. 101 Gilbert, AZ 85234 | innovativeprimarycareaz.com | 480.776.0626