Welcome to Colorado Primary Health Care **Adult New Patient History Form**

Name:_____ Today's Date: _____

Birthdate: _____

Preferred Language: _____

Do you have special communication needs for: ❑ Loss of Hearing ❑ Vision Problems ❑ N/A

Do you have Advance Directives (living will, etc.) in place? ❑ Y ❑ N ❑ I don't know

IMMUNIZATIONS: Have you had the following immunizations and if so, when?

Immunization		Year		
Pneumonia Shot	❑ Y		❑ N	
Flu Shot	❑ Y		❑ N	
Tetanus Shot	❑ Y		❑ N	*Did Tetanus Shot Include Whooping Cough?* ❑Y ❑ N

ALLERGIES: Please list any allergies you have, and your reaction:

Food or Drug Allergy	Reaction

MEDICATIONS: Please list medications you currently take (including over the counter medications): *Please list any additional medications on back of form*

Medication Name	Dose (mg)	How often

MEDICAL PROBLEMS: Please list any significant illnesses you have had.

Problem		Year	Problem		Year
❑ Yes	Allergies		❑ Yes	Scarlet Fever	
❑ Yes	Asthma		❑ Yes	Measles	
❑ Yes	Diabetes		❑ Yes	Mumps	
❑ Yes	Heart problems		❑ Yes	German Measles	
❑ Yes	Kidney problems		**Additional Problems**		
❑ Yes	Liver problems				
❑ Yes	Pneumonia				
❑ Yes	Seizures				
❑ Yes	Chickenpox				
❑ Yes	Rheumatic Fever				

HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES: Have you ever had a hospitalization, surgery, or serious injury?

Please use the back of this page for additional hospitalizations, surgeries or injuries

Year	Problem	Hospital

SPECIALIST VISITS: Which Specialists have you seen in the past 3 years?

Please use the back of this page for additional specialists you have seen.

Specialist Name	Reason	When

When was your last…

Screening	Year	Screening	Year
Physical Exam		Mammogram	
Colonoscopy		PAP Test	

Family History	Mother		Father		Brother / Sister		Brother / Sister		Brother / Sister		Brother / Sister		Other		Other	
Still Living?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If not, cause of death?																
Age at death?																
Diabetes																
Heart Disease																
Cancer (include type)																
Mental Illness																
Depression																

SOCIAL MEDICAL HISTORY

Do you Use Tobacco? ❑ Y ❑ N *Formerly?* ❑ *Y* ❑ *N* *Year Quit* _____	Smoke? ❑ Y ❑ N Amount Per Day_____ Chew ? ❑ Y ❑ N Amount Per Day_____
Do you Drink Alcohol? ❑ Y ❑ N *Formerly?* ❑ *Y* ❑ *N* *Year Quit* _____	Beer ❑ Y ❑ N Amount Per Week_____ Wine ❑ Y ❑ N Amount Per Week_____ Liquor ❑ Y ❑ N Amount Per Week_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Occupation: _____

Do you Exercise? ❑ Y ❑ N What type?_____Times per week?_____

Do you have a religious affiliation? ❑ Y ❑ N *If yes, what religion?* _____

Are there animals in the home? ❑ Y ❑ N *If yes, what type?* _____

Are you currently using recreational drugs? ❑ Y ❑ N ❑ Decline

Please List Persons Living in your home:

Name	Relationship to you	Age

Signature: _____ Date:_____