**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 |
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**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 |
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**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 |
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**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 |
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**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<br>*Formerly?* ❑ *Y* ❑ *N*<br>*Year Quit* _____ | Smoke? ❑ Y ❑ N Amount Per Day_____<br>Chew ? ❑ Y ❑ N Amount Per Day_____ |
| **Do you Drink Alcohol?** ❑ Y ❑ N<br>*Formerly?* ❑ *Y* ❑ *N*<br>*Year Quit* _____ | Beer ❑ Y ❑ N Amount Per Week_____<br>Wine ❑ Y ❑ N Amount Per Week_____<br>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 |
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Signature: _____ Date:_____