Batish Family Medicine

New Patient Health History Form

Full Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Local Pharmacy: _____ Mail Order Pharmacy: _____

Reason for your visit today: _____

Previous/current physician(s): _____

How did you hear about us? _____

Allergies

_____

_____

_____

Medication List

Medication Name	Dosage	How often?	30/60/90 day RX?	Refills needed?

Personal Medical History

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (Type _____)
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots/Clotting Disorder
- ☐ Cancer (Type _____)
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease/Stents
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (Type 1 or 2)
- ☐ Enlarged Prostate (BPH)
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Disease/Heart Failure
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis

Women Only:

- ☐ Abnormal PAP smear

# of Pregnancies: _____

# of Children: _____

Last Menstrual Period:

_____

Other Medical Problems (not listed above)

_____

_____

Full Name: _____ **Date of Birth:** _____

Health Maintenance

	Date	Results
Colonoscopy / Cologuard		
Mammogram (women only)		
PAP smear (women only)		
DEXA (Bone density)		

Surgical History

Type of Surgery (example: hysterectomy)	**Date (year)**

Social History

What is your occupation? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner

Who do you live with? _____

Tobacco Use: ☐ Current User ☐ Never User ☐ Former User

Type Used: _____ Amount per day: _____ # of Years Used: _____ Quit Year: _____

Alcohol Use: ☐ Current User ☐ Never User ☐ Former User

Type of alcohol: _____ Amount per week: _____

Drug Use / Substance Abuse: ☐ Current User ☐ Never User ☐ Former User

Firearms Exposure: Are firearm(s) kept in the household? ☐ Yes ☐ No **If yes, continue answering below:**

Are firearm(s) properly secured? ☐ Yes ☐ No Are firearm(s) kept loaded? ☐ Yes ☐ No

Family History

☐ Please check here if adopted (no family history available)

Biological Family Member	**Deceased?**	**List any medical problems (with age at diagnosis if known)**
Mother/Parent 1		
Father/Parent 2		
Sister(s)		
Brother(s)		
Daughter(s)		
Son(s)		