TEMESCAL CREEK MEDICINE

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NEW PATIENT HEALTH HISTORY

NAME: _____ **DATE:** _____

To help us have the most complete information, please take a moment to answer the following questions.

MEDICAL HISTORY

Do you have any ongoing medical problems for which you see a doctor or are taking a medication?

MEDICATION HISTORY

MEDICATION	DOSAGE	FREQUENCY

MEDICATION ALLERGIES

List medication and type of reaction (eg rash, nausea, shock, etc)

SURGICAL HISTORY

Have you had any surgeries in your lifetime? Please include surgery, year, name of surgeon and any complications.

OTHER HEALTHCARE PROVIDERS

Do you see any other doctors on a regular basis? Please list below:

SOCIAL HISTORY

Where do you live?

Who lives at home with you?

Do you have a partner/significant other?

Do you have any children?

What do you do for work?

What do you enjoy outside work?

How stressful is your life? Scale of 1-10

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

Do you have sex with men, women or both? ☐ Men ☐ Women ☐ Both

What type of contraception do you use?

Female: # of Pregnancies: # of Children:

BEHAVIOR AND LIFESTYLE

Do you use tobacco? ☐ Never ☐ Former ☐ Current, sometimes ☐ Current, daily

In an average week, how many alcoholic drinks do you consume?

☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-13 ☐ 14 or more

On days when you drank alcohol, how often did you have 4 or more alcoholic drinks on one occasion?

☐ Never ☐ Once during the week ☐ 2–3 times during the week ☐ > 3 times during the week

Do you exercise on a regular basis? ☐ Yes ☐ No

How many days per week?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

How many minutes per session?: ☐ 10-20 min ☐ 20-40 min ☐ 40-60min ☐ >1 hour

How intense was your typical exercise?

☐ Light (like stretching or slow walking)

☐ Moderate (like brisk walking)

☐ Heavy (like jogging or swimming)

☐ Very heavy (like fast running or stair climbing)

☐ I am currently not exercising

Do you believe you eat a varied, balanced diet? ☐ Yes ☐ No

If your answer was NO, what would you say is the main issue?

☐ Poor food choices ☐ Eating too much ☐ Not eating enough

FAMILY HISTORY

For each family member please include the **year of birth** and any **significant medical conditions** such as cancer or heart disease. If the family member is no longer alive, include **age of death and cause**.

Father:

Mother:

Siblings:

Other:

PREVENTIVE CARE AND SCREENINGS

Have you had a Tetanus shot within the last 10 years?	☐ No	☐ Yes, date?
Have you ever had the Pneumonia vaccine (Pneumovax)?	☐ No	☐ Yes, date?
Have you ever had the Shingles vaccine (Zostavax)?	☐ No	☐ Yes, date?
Have you ever had a Sigmoidoscopy or Colonoscopy?	☐ No	☐ Yes, date?
Female:		
Date of last pap smear?		
Have you ever had an "abnormal" pap smear?	☐ No	☐ Yes, date
Date of last mammogram?		
Have you ever had an "abnormal" mammogram?	☐ No	☐ Yes, date

SELF-EVALUATION

How would you rate your health in general? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are you confident in managing your health and health problems? ☐ Yes ☐ No ☐ Maybe

What are your goals for your health/healthcare?

ANYTHING ELSE?

You have several options for returning this document. 1) Fax to 877 512-3804 2) Email to tcmadmin@tcreekmed.com 3) Bring to your visit. We are looking forward to seeing you!