Baptist Primary Care

New Patient Form

Name:_____

DOB: _____

Past History

Last pap smear:	Allergies: ☐ None List Allergies:
Last mammogram/ prostate exam: result:	
Last colonoscopy: Last eye exam:	# of children _____ # of pregnancies _____
Please List All Personal Illnesses/Injuries and approximate dates:	Please list all past surgeries with approximate dates:

Social History

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Most recent occupation: _____

Smoker? Yes ☐ No ☐ How much? _____ packs/ day How long? _____ / years Date quit: _____

Alcohol? Yes ☐ No ☐ How much? _____/ day When? _____ Caffeine (coffee, tea, colas) How much? _____/ day

Illicit drug use? None ☐ Currently using: _____ Prior problem? Yes ☐ No ☐ explain:_____

Exercise? Yes ☐ No ☐ How often? _____

Family History

Check ONLY the boxes that are POSITIVE: Diabetes ☐ Heart disease ☐ High blood pressure ☐ Stroke ☐ TB ☐ Cancer ☐

Kidney disease ☐ Anemia ☐ Arthritis ☐ Mental illness ☐

Please explain any boxes that are checked: _____

_____

Mother: Living ☐ Deceased/ cause: _____ Age: _____ Brother(s) # ____ Living ☐ Deceased/ cause:_____ Age: _____ Father

Living ☐ Deceased/ cause: _____ Age: _____ Sister(s) # _____ Living ☐ Deceased/ cause:_____ Age: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER, HERBAL SUPPLEMENTS, AND BIRTH CONTROL..

MEDICATION	DOSAGE/ FREQUENCY