New Patient Packet

Patient Name:_____
Date of Birth:_____

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ALLERGIES			
Agent/Medication	***Reactions[i.e. hives/itching]***	***Agent/Medication***	***Reactions [i.e.hives/itching]***
Latex Allergy	**YES / NO**		

MEDICATIONS			
Medication Name	***Dose (mg, mcg, units)***	***Frequency/Instructions***	***Doctor that Prescribes***
Aspirin?			
Vitamins?			

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FAMILY HEALTH HISTORY Please list below the health history of your blood (genetic) first degree relatives, including **Diabetes, Cardiac/Heart Disease, or Cancers**				
Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Paternal Grandmother:				
Paternal Grandfather:				
Mother:				
Maternal Grandmother:				
Maternal Grandfather:				
Brother(s):				
Sister(s):				
Children:				

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PAST SURGICAL/HOSPITALIZATION HISTORY			
Name	***Left or Right***	***Date***	***Comments***

CURRENT HEALTH CONDITIONS			
Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***
❑ High Cholesterol		Other(s):	
❑ Thyroid Disease-Hypo/Hyper			
❑ COPD, Pneumonia, Emphysema or Asthma			
❑ Diabetes			
❑ GERD/Acid Reflux/Stomach Problems			
❑ Depression or Anxiety			
❑ Heart Problems (Cardiac Stents/Atrial Fibrillation)			
❑ Hypertension			
❑ Cancer			
❑ Arthritis			
❑ Kidney Disease			
❑ Stroke			
❑ Anemia or Blood Disorders			

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SOCIAL HISTORY					
Smoking	**Start Date:**	**Quit Date:**	**Type: [CIGARETTE/PIPE /CIGAR]**	**Packs/Day**	**Years**
Smoking Status: [circle]	Current Every Day smoker Current Some Day Smoker Former Smoker Heavy Tobacco Smoker Light Tobacco Smoker Never Assessed Never Smoked Passive Smoke Exposure - Never Smoker Smoker, Current Status Unknown Unknown if Ever smoked Current Status Unknown				
Smokeless Tobacco Status: [circle] Current User Former User Never Used Unknown	**Quit Date:**	**Types: [SNUFF/CHEW]**	**ANY COMMENTS FOR TOBACCO**		
Alcohol use Status: [CIRCLE] Not Used No Yes	**Use/Week**	**Type: [1.5 oz of liquor,12 oz of beer,5 oz of wine, Mix drink containing 1.5 shots of alcohol]**	**ANY COMMENT FOR ALCOHOL**		
Drug Use Status: [CIRCLE] Not Asked No Yes	**Use/Week :[1,2,5,10]**	**Types: [COCAINE, IV, MARIJUANA, METHAMPHETAMINES]**	**ANY COMMENT FOR DRUG USE**		
ADVANCED DIRECTIVES		**COPY AVAILABLE FOR OFFICE RECORDS: YES / NO**			

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Standardized Health Maintenance Tests/Procedures			
PROCEDURES	**Date**	**ORDERING PROVIDER**	**LOCATION COMPLETED**
Aortic Duplex			
Chest X-ray			
Colonoscopy			
Osteoporosis Scan/DEXA			
Diabetic Eye Exam			
Diabetic Foot Exam			
EKG – baseline			
Mammogram			
Pap			
PFT			

IMMUNIZATIONS	**Date Recieved**
Flu Vaccine	
Pneumonia Vaccine (PCV 23)	
Prevnar 13	
Tetanus	
Tdap	
Gardasil	
Zostavax (Shingles Vac.)	
Hepatitis B Vaccines	

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REMINDER:

Please bring ALL bottles of your medication (including prescription pills and over-the-counter vitamins/minerals) as this will ensure the most accurate medication list!

Sincerely,

Geisinger Holy Spirit Medical Group