SFM New Patient Health History

Name: _____ Date of Birth: _____

Marital Status: _____Occupation: _____

Language (*Check one box*): ☐ English ☐ Indian ☐ Spanish ☐ Russian ☐ Other

Race (*Check one box*): ☐ American Indian/Alaska Native ☐ Asian ☐ Hawaiian/Pacific Islander

☐ White ☐ Black/African American ☐ Hispanic/Latin ☐ Other ☐ Refuse to Report

Ethnicity (*Check one box*): ☐ Hispanic/Latin ☐ Not Hispanic/Latin Race ☐ Refuse to Report

Pharmacy/Location: _____ Phone: _____

Medication Allergies and Reactions: _____

_____

Please list current medications below:

Medication	Dosage	Frequency	Reason Taken

Please list any current or past medical illnesses for which you have been treated:

Please list any surgeries or hospitalizations:

Family History (*Please mark all that apply*):

☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Stroke
☐ Heart Disease	☐ Thyroid Disorder	☐ Arthritis	☐ Seizures
☐ High Cholesterol	☐ Asthma	☐ Ulcers	☐ Mental Illness

Social History:

Do you smoke or use tobacco products?	Yes	No	Packs per day_____ Years _____
Do you drink alcohol?	Yes	No	How much? _____
Do you use recreational drugs?	Yes	No	Which ones?_____
Do you exercise?	Yes	No	How often? _____

Immunizations: (Year)

Tetanus_____ Chicken Pox_____ Measles/Mumps/Rubella_____

Flu_____ Pneumonia_____ Hepatitis B_____

Hepatitis A_____

Preventive Health: (Month/Year)

Last mammogram_____ Last pap smear_____

Last rectal_____ Last cholesterol_____

Last colonoscopy_____ Last stress test_____

Last prostate exam_____ Last chest x-ray_____