OhioHealth

MRN (office use only):_____

New Patient History Form (Adult)

New Patients, please take a moment to fill out both pages and complete all areas to the best of your knowledge. In doing so we will have a better understanding of you and target any concerns/issues you may have. **Existing Patients** please fill out both pages and complete all areas to the best of your knowledge. This will allow us to review your medical history and updates changes that may have occurred over the past year.

Name: _____ Date of Birth: _____ Date: _____

Marital Status: _____ Name of Spouse or Significant Other: _____

Children (include age): _____

Education: _____Profession:_____

Do you exercise regularly? **Y N** _____

Do you drink alcohol? **Y N** If yes, how many per day? _____ How many per week? _____

Do you currently smoke or have you smoked in the past? If yes, how much? _____For how long? _____

Do you currently have a living will? **Y N** Do you have a power of attorney? **Y N**

PAST MEDICAL HISTORY: Please list all medical conditions for which you have been treated in the past

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

PAST SURGICAL HISTORY: Please list all operations and dates

1.	4.
2.	5.
3.	6.

IMMUNIZATIONS: Please date your most recent immunization

Hepatitis A_____	Flu Shot_____	Tetanus_____	Shingles_____
Hepatitis B_____	Chicken Pox_____	Meningitis_____	
HPV_____	Pneumonia_____	MMR_____	Other_____

MEDICATIONS: Please list all medications your are currently taking and include dose and frequency, this includes over the counter and herbal supplements.

1.	6.
2.	7.
3.	7.
4.	9.
5.	10.

ALLERGIES: Please list all medications you are allergic to and the allergic reaction that occurs

Please check box if you have no known allergies: □

1.	3.
2.	4.

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Name: _____ Date of Birth: _____

FAMILY HISTORY: Some medical conditions run in families. Examples are heart attacks, diabetes, depression, arthritis, cancers and many others. In the space below, please list any medical conditions in close family members, along with the person who has them (grandparent, parent, brother, sister, child):

WOMEN:

Number of pregnancies_____ Children_____ Miscarriages_____ Abortions_____

Last pap smear_____ Have you had an abnormal pap? **Y N**

Last period_____ Age at first period_____ Last bone density scan_____

Last Mammogram_____ Age at Menopause_____

BOTH:

Last colonoscopy / sigmoidoscopy_____

Thank you for taking time to fill out the forms. Please sign and date:

Patient Signature_____ Date: _____

Physician Signature_____ Date: _____