York Medical Clinic, P.C.
family medicine

New Patient Health History

Name:_____ **Date:**_____

Date of Birth:_____ **Age:**_____ **Marital Status:** M S W D **Veteran:** YES NO

Health History

Yes	No	Condition	Explain
		Alcoholism/Chemical Dependency	
		Anemia	
		Arthritis/Gout	
		Asthma	
		Bleeding Disorders	
		Breast Lump(s)	
		Cancer(s)	
		Chicken Pox	
		COPD/Emphysema	
		Depression or Suicide Attempts	
		Diabetes	Last A1c:
		Ear/Sinus Problems	
		Epilepsy	
		Gastrointestinal/Stomach Problems	
		Heart Disease or Pacemaker	
		Hepatitis (A, B or C)	
		High Cholesterol	
		High Blood Pressure	
		Kidney Disease	
		Migraine Headaches	
		Multiple Sclerosis	
		Pneumonia	
		Prostrate Problems	
		Psychiatric or Mental Health Care	
		Rheumatic Fever	
		Sexually Transmitted Diseases	
		Sleep Disorders or CPAP Use	
		Stroke	
		Thyroid Problems	
		Tuberculosis	
		Vaginal Infections	
		Other Chronic Disease:	

Allergies (medications, food, latex or environmental)	Reaction

Health Habits

	Never Use	Daily Use (indicate amount)	Some Days (indicate how often)	Formerly/Past Use
Caffeine				
Tobacco				
Drugs				
Alcohol				

Immunizations

Have you ever had any of these vaccines? If yes, indicate what year given.

Pneumonia:_____ Tetanus:_____ Shingles:_____

Prevnar 13:_____ Last Flu Shot:_____ Other:_____

Current Medications	Dose and Frequency

Serious Injuries / Illnesses / Surgeries / Hospitalizations	Year and Location

Preventative Health History	Year and Location
Mammogram	
Colon Cancer Screening (Colonoscopy, ColoGuard, Fecal Cards)	
PAP (cervical cancer screening)	
Bone Density Testing (Dexa Scan)	
Last Eye Exam	

Family History

Relation	Age at Death	Cause of Death
Father		
Mother		
Brother(s)		
Sister(s)		

	Father	Fathers Father	Fathers Mother	Mother	Mothers Father	Mothers Mother	Siblings	Children
Asthma	❑	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
Degenerative Joint Disease	❑	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑
Lung Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑	❑

Emergency Contact Person:

_____

Emergency Contact Phone:

_____