Northfield Hospital + Clinics

New Patient Adult Information

PATIENT INFORMATION

Name: ____ Today' Date: _______________________

Date of Birth: ________________

Allergies: ____

Interpreter Needed: ☐ Yes ☐ No Is patient adopted: ☐ Yes ☐ No

PAST MEDICAL HISTORY *(List ANY conditions you have been treated for currently or in the past.)*

Diabetes	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	COPD	☐ Yes	☐ No
Blood Pressure	☐ Yes	☐ No	Cholesterol	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Stroke	☐ Yes	☐ No

Please list any others not listed above:

____

____

____

Please list below any surgeries or other procedures you have had:

What? ___________________________ When? _____________

What? ___________________________ When? _____________

What?___________________________ When? _____________

What? ___________________________ When? _____________

Have you ever had?

Colonoscopy ☐ Yes ☐ No When? _____________

Mammogram ☐ Yes ☐ No When? _____________

Dexa Scan ☐ Yes ☐ No When? _____________

(Females) Have you ever had a PAP Smear? ☐ Yes ☐ No

Date of Last PAP __________________________

Results of Last PAP ☐ Normal ☐ Abnormal

SOCIAL HISTORY

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Other: ______________________________

Occupation: ____

Children ☐ Yes ☐ No Number of living children? ______________

Are you sexually active? ☐ Yes ☐ No With Men? ☐ Yes ☐ No With Women? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No How often per week? ________ What type of exercise? ________

Continued on back...

CONTINUED….

Tobacco

Are you a current smoker? ☐ Yes ☐ No How many per day? _______________ How many years? _____________

Do you use any other type of tobacco? ☐ Yes ☐ No If yes, what? __________________________________

Alcohol

Do you drink alcohol? ☐ Yes ☐ No Drinks per week on average? _____ Drinks per month on average? _______

Drug Use

Do you use drugs currently? ☐ Yes ☐ No or have you in the past? ☐ Yes ☐ No What? _________________

FAMILY HISTORY – Does/did anyone among your blood relatives have or had any of the following?

Heart Disease ☐ Yes ☐ No Who and what age? ____

Stroke ☐ Yes ☐ No Who and what age? ____

Colon Cancer ☐ Yes ☐ No Who and what age? ____

Prostate Cancer ☐ Yes ☐ No Who and what age? ____

Breast Cancer ☐ Yes ☐ No Who and what age? ____

Other Cancer ☐ Yes ☐ No Who, what and what age? ____

Diabetes ☐ Yes ☐ No ☐ Type 1 ☐ Type 2 Who? ____

Mental Illness ☐ Yes ☐ No Who and what? ____

Liver or Kidney Disease ☐ Yes ☐ No Who, what and what age? ____

Seizure Disorder ☐ Yes ☐ No Who and what age? ____

Any other disease that runs in your family? ____

Are you experiencing any of the following symptoms? Please circle:

GENERAL
Fever
Chills
Fatigue
Weight change

EYES
Vision change
Redness/irritation
Discharge
Pain

ENT
Sore throat
Ear pain
Congestion/pressure
Nose bleeds

CARDIOVASCULAR
Chest pain
Leg swelling
Irregular/fast heartbeat
Difficulty breathing

RESPIRATORY
Shortness of breath
Cough
Wheezing
Sputum or blood

GASTROINTESTINAL
Abdominal pain
Nausea/vomiting
Constipation/diarrhea
Blood in stools

URINARY
Pain/blood
Frequency
Incontinence
Hesitancy

GYNECOLOGICAL
Discharge
Irregular bleeding
Low libido
Pelvic pain

MALE
Discharge
Erectile dysfunction
Weak stream
Testicular lump/pain
Low libido

MUSCLES
Joint swelling
Weakness
Pain
Stiffness

SKIN
Rash
Lesion
Mole changes
Open sores

NEUROLOGICAL
Headaches
Dizziness/fainting
Numbness/tingling
Tremor

PSYCHIATRY
Depression
Anxiety
Memory problems

ENDOCRINE
Heat/cold intolerance
Excessive thirst
Excessive urination

HEMATOLOGIC
Easy bleeding
Easy bruising
Past transfusion

ALLERGIC
Hives
Tongue swelling
Allergic reaction