NEW ADULT PATIENT

BARRY POINTE FAMILY CARE, LLC
Your Medical Home

Name: _____

Birth Date: _____ Today's Date: _____

Please tell us the **REASON FOR TODAY'S VISIT**. Please list in **ORDER OF IMPORTANCE** as we may not be able to fully address all issues today: _____

_____

_____

Please list **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea, swelling)

Please provide **IMMUNIZATION HISTORY:** **Please provide a copy of immunization record.**

	Yes	No	Date		Yes	No	Date
Tetanus-Diphtheria Booster				Hepatitis A Vaccine			
Influenza Vaccine (Flu shot)				Hepatitis B Vaccine			
Pneumococcal Vaccine				Human Papilloma Virus (HPV)			
Tuberculosis (TB) Skin Test				Varicella Vaccine			

Please provide your **PAST MEDICAL HISTORY**:

_____ADD/ADHD
_____Abdominal Pain
_____Allergies
_____Anemia
_____Angina (chest pain)
_____Anxiety
_____Arthritis
_____Asthma
_____Atrial Fibrillation
_____BPH (enlarged prostate)
_____Blood clots
_____Bronchitis
_____Cancer, type _____
_____Concussion, CHI
_____Congenital heart disease
_____Constipation
_____COPD (emphysema)
_____Crohn's disease
_____CVA (stroke)
_____Depression
_____Diabetes
_____Fracture
_____Gallbladder disease
_____GERD (reflux)
_____Headaches
_____Hepatitis C
_____High cholesterol
_____High blood pressure
_____Irritable bowel disease
_____Liver disease
_____Menstrual problems
_____Migraine headaches
_____MI (heart attack)
_____Osteoarthritis
_____Osteoporosis
_____Peptic ulcer disease
_____Pneumonia
_____Renal disease (kidneys)
_____Seizure disorder
_____Thyroid disease

For Nurse Use Only: Height_____ Weight_____ Temp_____ BP_____ Pulse_____ Resp_____

Please tell us about any **SURGERIES** you have had, you may indicate the **date/year if know**n:

_____Angioplasty
_____Angioplasty with stent
_____Appendix
_____Arthroscopy knee
_____Back surgery
_____CABG (open heart surgery)
_____Carpal tunnel release
_____Cataract
_____Cholecystectomy(gallbladder)
_____Cholectomy (colon removed)
_____Colostomy
_____Gastric bypass
_____Hernia repair
_____Hip replacement
_____Knee replacement
_____LASIK
_____Liver biopsy
_____ORIF(repair broken bone)
_____Pacemaker
_____Small bowel resection
_____Thyroidectomy
_____Tonsillectomy

Gender Specific Male:

_____Prostatectomy
_____TURP
_____Vasectomy

Gender Specific Female:

_____Breast augmentation
_____Bilateral tubal ligation
_____Breast biopsy
_____Cesarean section
_____D & C
_____Hysterectomy
_____Mastectomy
_____Breast reduction

Please list any **ADDITIONAL PAST MEDICAL HISTORY** or **PAST SURGICAL HISTORY** and date/year if known:

_____

Please provide your **FAMILY HISTORY**:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Alcoholism					
Allergies					
Alzheimer's disease					
Asthma					
Blood disease					
Coronary artery disease (heart disease)					
Premature heart disease (M <55, F <65)					
Cancer, type _____					
CVA (Stroke)					
Depression					
Developmental delay					
Diabetes					
Eczema					

	Mother	Father	Sister	Brother	Other
Hearing deficiency					
High cholesterol					
High blood pressure					
Irritable bowel disease					
Learning disability					
Mental illness					
Migraines					
Obesity					
Osteoarthritis					
Osteoporosis					
Peripheral vascular disease (blood clots)					
Renal (kidney) disease					
Seizure disorder					
Other:					

Please provide your **SOCIAL HISTORY**:

Do you smoke: ___Yes ___No ___Former Type of tobacco: _____ Packs per day: _____

Years smoked: _____ Year quit: _____ Have you ever tried to quit? ____Yes ____No

Do you drink alcohol: ____Yes ____No ____Former Type of alcohol: _____ Frequency: _____

Amount: _____ When was your last drink? _____

FOR FEMALES ONLY:

Age of First Period: _____ Date of last Menstrual Period: _____ Date of last Mammogram: _____

Date of last Pap Smear: _____ Any history of abnormal Pap Smear? ____Yes ____No If yes, when: _____

Are Periods regular: ____Yes ____No Do you have pain with periods: ____Yes ____No

Is flow: ____Normal ____Heavy ____Light ____Spotting

Number of pregnancies: ____ Number of live children: ____ Number of miscarriages: ____ Number of abortions: ____