COAL CREEK FAMILY MEDICINE
NEW PATIENT INFORMATION SHEET

NAME: _____ GENDER: Female / Male DOB: _____ DATE: _____

ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder Problems / Incontinence
Bleeding Problems
Cancer: _____
Crohn's Disease
COPD/ Emphysema
Dementia / Memory Loss
Depression
Diabetes Type 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Headaches
Hiatal Hernia
High Blood Pressure
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Kidney Stones
Kidney Disease
Lupus
Liver Disease
Macular Degeneration
Migraines
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period	Date:		Normal / Abnormal
Colonoscopy	Date:	YES / NO	Normal / Abnormal
Mammogram	Date:	YES / NO	Normal / Abnormal
Dexa (Bone Density)	Date:	YES / NO	Normal / Abnormal
Pap	Date:	YES / NO	Normal / Abnormal
Last Eye Exam	Date:	YES / NO	Normal / Abnormal
Last Dental Exam	Date:	YES / NO	Normal / Abnormal
Last Flu Shot	Date:		

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

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Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility

☐ Other: _____

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never Comments

(Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Cancer: _____	DVT (Blood Clot)	Migraines
Anemia	COPD/Emphysema	Heart Disease	Osteoporosis
Asthma	Dementia	High Cholesterol	Stroke
Arthritis	Depression	High Blood Pressure	Thyroid Disorder
Bipolar Disorder	Diabetes 1 or 2	Kidney Disease	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Cancer: _____	DVT (Blood Clot)	Migraines
Anemia	COPD/Emphysema	Heart Disease	Osteoporosis
Asthma	Dementia	High Cholesterol	Stroke
Arthritis	Depression	High Blood Pressure	Thyroid Disorder
Bipolar Disorder	Diabetes 1 or 2	Kidney Disease	

Other: _____

SIBLINGS: _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____