WANG & JIANG MD PA

New Patient Health History

Name ______________ **DOB** ______________ **Date** ______________

Socially History

Occupation: ______________

Employer: ______________

Degree/Highest Education Level: ______________

Marital Status (circle one): Single Partner Married Divorced Widowed

Spouse/Partner's Name: ______________ Number of children: ______________

Number of grand children: ______________ Number of great grandchildren:

Who lives at home with you? ______________

Function Independent, minimal assistant, moderate assistant, full assistant

In the last 12 months, any fall? yes how many?

no

Tobacco Use

Smoker? (circle one) yes no never

If No: Have you ever? yes no

If Yes: Quit date: ________ How many years: ________ Packs/day: ________

Other tobacco use (circle one): Pipe Cigar Snuff Chew

Alcohol Use

Do you drink alcohol? yes no

\# of drinks per week: ______________ Type? (circle one) Beer Wine Liquor

Drug Use

Do you use marijuana or other recreational drugs? (circle one) yes no

Have you ever used needles to inject drugs? (circle one) yes no

In the past 2 weeks, have you been bothered by:

Feeling sad or empty	yes	no
Feelings of worthlessness	yes	no
Less ability to think or concentrate	yes	no
Less interest in daily activities	yes	no
Tearfulness	yes	no
Thoughts of death or suicide	yes	no
Weight loss or gain when not dieting	yes	no

Do you have any allergies to medications? yes no

If yes, what are the medications and your reactions: ______________

Name ____________________ **DOB** ________________ **Date** ___________

Preventative Screenings (Please Circle Yes or No)

Colonoscopy	Yes	when__________________	No
Mammogram	Yes	When__________________	No
Pneumonia shot	Yes	when__________________	No
Flu shot	yes	when__________________	NO
Pap smear	Yes	When__________________	No
Diabetes Eye exam	Yes	When__________________	No
Last Annual physical	yes	when__________________	No

Personal Medical History: Do you have now or previously had any of the following?

Alcohol/Drug abuse	Yes	No	Type: ____________________
Anxiety	Yes	No	
Asthma	Yes	No	
Arthritis	Yes	No	Type: ____________________
Bladder/Kidney Problems	Yes	No	
Blood Clot	Yes	No	Where: ____________
Cancer	Yes	No	
*If yes then what type	____________	&	Where: ____________________
Hypo/hyperthyroidism	Yes	No	
Heart Disease	Yes	No	Type: ____________________
Diabetes	Yes	No	Type: ____________________
Heart Burn	Yes	No	
Hypertension	Yes	No	
Gout	Yes	No	
High Cholesterol	Yes	No	
Liver Disease	Yes	No	

Family Medical History			**Type/Where**	**Family Member**
Alcohol/Drug abuse	Yes	No	____________	____________
Allergies	Yes	No	____________	____________
Anxiety	Yes	No		____________
Asthma	Yes	No		____________
Arthritis	Yes	No	____________	____________
Bladder/Kidney Problems	Yes	No		____________
Blood Clot	Yes	No	____________	____________
Cancer	Yes	No	____________	____________
Hypo/hyperthyroidism	Yes	No	____________	____________
Heart Disease	Yes	No	____________	____________
Diabetes	Yes	No	____________	____________
Heart Burn	Yes	No		____________
Hypertension	Yes	No		
Gout	Yes	No	____________	____________
High Cholesterol	Yes	No		____________
Liver Disease	Yes	No	____________	____________

Name ________________________ DOB _________________________ Date ________________

Surgical History: Have you ever had surgery/procedures for any of these reasons? (circle one)

Appendix	yes	no	Year: ______________
Back	yes	no	Year: ______________
Heart	yes	no	Year: ______________
Hip	yes	no	Year: ______________
Hysterectomy	yes	no	Year: ______________
C-Section	yes	no	Year: ______________
Bilateral Tubal Ligation (Tubes tied)	yes	no	Year: ______________
Gallbladder removal	yes	no	Year: ______________
Breast Surgery	yes	no	Year: ______________
Tonsillectomy	yes	no	Year: ______________
Hernia Repair	yes	no	Year: ______________

Other: ____

____

Please write down any/all current medications, dosages, and directions.

Medication	Dosage	Directions