# Baptist Primary Care

New Patient Form

Name:_____

DOB: _____

## Past History

| | |
|---|---|
| Last pap smear: | Allergies: ☐ None List Allergies: |
| Last mammogram/ prostate exam: result: | |
| Last colonoscopy: Last eye exam: | # of children _____ # of pregnancies _____ |
| | |
| Please List All Personal Illnesses/Injuries and approximate dates: | Please list all past surgeries with approximate dates: |
| | |
| | |
| | |

## Social History

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Most recent occupation: _____

Smoker? Yes ☐ No ☐ How much? _____ packs/ day How long? _____ / years Date quit: _____

Alcohol? Yes ☐ No ☐ How much? _____/ day When? _____ Caffeine (coffee, tea, colas) How much? _____/ day

Illicit drug use? None ☐ Currently using: _____ Prior problem? Yes ☐ No ☐ explain:_____

Exercise? Yes ☐ No ☐ How often? _____

## Family History

Check ONLY the boxes that are POSITIVE: Diabetes ☐ Heart disease ☐ High blood pressure ☐ Stroke ☐ TB ☐ Cancer ☐

Kidney disease ☐ Anemia ☐ Arthritis ☐ Mental illness ☐

Please explain any boxes that are checked: _____

_____

Mother: Living ☐ Deceased/ cause: _____ Age: _____ Brother(s) # ____ Living ☐ Deceased/ cause:_____ Age: _____ Father

Living ☐ Deceased/ cause: _____ Age: _____ Sister(s) # _____ Living ☐ Deceased/ cause:_____ Age: _____

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER, HERBAL SUPPLEMENTS, AND BIRTH CONTROL..**

| MEDICATION | DOSAGE/ FREQUENCY |
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