Providence Medical Group / Glisan Clinic
New Patient Health History Form

Name: ____________________________________ **When was your last Dr. Visit?** _________________

Date of Birth: ______________________________ **Name of previous Provider:** __________________

Gender: ___________________________________ **Specialist(s) you currently see or have seen:** _____

Occupation: _______________________________ ____

Medical History:

____ ____

____ ____

____ ____

____ ____

Medications: (Please include all medications including over-the-counter, topical, vitamins)

____ ____

____ ____

____ ____

____ ____

Allergies: (Sensitivities or Intolerances)

____ ____

____ ____

____ ____

Hospitalization: (Date/Reason/Hospital)

____ ____

____ ____

____ ____

Surgeries: (Date/Surgery)

____ ____

____ ____

Please continue on other side

Family History: (Diabetes, Heart Disease, Cancer, High Blood Pressure, Mental Illness, etc.)

	Age	Alive (Yes/No)	Health Problems
Mother			
Father			
Sister			
Brother			

Daughter ______________________________________ Son ______________________________________

Other (Please specify) ____

Female Patients Only:
Last Menstrual Period: _________________ Birth Control Type: ____________________ Last PAP: ___________

Total Pregnancies: _______________ Vaginal: ___________ C-Section: ___________________________________

Abortion: ________________ Miscarriage: ___________________ Early Delivery: Yes/No __________________

Children: ________________ Adopted: ______________________ Stepchildren: _________________________

Please circle any that apply:
Tobacco use: Yes/No/Prior/Never Smoke/Chew/Vape/Other: _____ Amount/Day: _____ Quit Date: _____

Alcohol use: Yes/No/Prior/Never Wine/Beer/Liquor/Other: ______ Amount______ per: day/week/month

Drug use: None/History of/Current use: Marijuana/Cocaine/Heroin/Meth/Psychotropic/Other: ___________
Amount/Day: _______ Quit Date: ________

Are you sexually active? Yes /No With? Male/Female/Both
Marital Status: Married/Single/Widow/Divorced/Separated/Partnered

Have you had any problems with below systems within the last month? (Please circle)

Heart Lungs/Breathing Kidneys/Urine Digestive Skin Joints

Allergies Mental Health Reproductive/Sexual Vision Hearing

Weight Changes Headaches Neurologic Thyroid/Blood Sugar Other: _____________

Preventive/Screening Services: (When was your last…)
Colonoscopy: ___________ Bone Density: ___________ Mammogram: ___________ Tetanus Shot: ___________
Fasting Blood Work (cholesterol/blood sugar): ______________________________

Other Healthcare Concerns:

____