WHITE HOUSE CLINICS

Adult New Patient History

Name: _____

Date of Birth: _____ **Date:** _____

For Internal Use Only:

Does patient need a translator? ☐ Yes ☐ No WHC Employee Initial _____

Does patient need assistance with reading or writing? ☐ Yes ☐ No WHC Employee Initial _____

Please list the other doctors you see:

Please list any allergies:

Past Medical History	Yes	No
Acid Reflux		
Anxiety		
Asthma		
Bipolar Disorder		
Blood Clot (DVT/PE)		
Cancer		
Chronic Pain		
COPD		
Coronary Artery Disease		
Crohn's Dis/Ulcerative Colitis		
Depression		
Diabetes		

	Yes	No
High Blood Pressure		
High Cholesterol		
Enlarged Prostate		
Heart Attack		
Heart Valve Problem		
Hepatitis		
Hemophilia (Free Bleeder)		
Kidney Disease		
HIV/AIDS		
Migraines		
Peripheral Artery Disease		
Rheumatoid Disease		

	Yes	No
Seizure Disorder		
Stroke		
Seasonal Allergies		
Substance Abuse/Alcoholism		
Thyroid Problem		
Tuberculosis		
Other:		
Other:		
Other:		
Other:		
Other:		
Other:		

Surgical History		Year			Year
☐	Appendix Removed		☐	Hernia Repair (Type: _____)	
☐	Back Surgery		☐	Hysterectomy: Partial or Complete	
☐	Bladder Surgery		☐	Orthopedic Surgery	
☐	Cataract		☐	Tonsils Removed	
☐	C Section		☐	Tubal Ligation	
☐	Ear Tubes		☐	Vasectomy	
☐	Heart Catheterization:		☐	Other:	
☐	Gallbladder Removal		☐	Other:	
☐	Heart Bypass		☐	Other:	

Family History: Check which family members have had the following

	None	Mother	Father	Sister	Brother	Other
Cancer Type: _____	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Substance Abuse/Alcoholism	☐	☐	☐	☐	☐	☐
Other (specify): _____	☐	☐	☐	☐	☐	☐

Social History

☐ Married ☐ Single ☐ Widow ☐ Divorced

Do you have children? ☐ Yes ☐ No Number of Children ____ Do you have custody? ☐ Yes ☐ No

Job Occupation _____ ☐ Retired

☐ Disabled If disabled, please list reason: _____

Tobacco Use ☐ None ☐ Quit (date) _____ Still use: ☐ Cigarettes ☐ Smokeless/Chew ☐ Cigars ☐ Pipe

Check the amount of tobacco you use(d) each day. ☐ ½ pack/can ☐ 1 pack/can

How many years did/have you smoked? _____ ☐ 2 packs/cans ☐ More

Alcohol Use ☐ None (A drink is 1 shot of liquor, 1 glass of wine, or 1 bottle/can of beer.)

☐ Less than 1 drink/month ☐ 1-15 drinks/month ☐ 4-14 drinks/week ☐ More than 2 drinks/day

Drug Use ☐ Yes ☐ No ☐ Quit (date) _____ If yes, what do you use regularly? _____

HIV/AIDS Screening ☐ Yes ☐ No If yes, where and when? _____

Health Maintenance

Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

Have you seen a dentist in the past year? ☐ Yes ☐ No

Date of your last colonoscopy: _____ Date of your last pneumonia shot: _____

Date of your last tetanus shot: _____ Date of your last shingles shot: _____

Date of your last flu shot: _____ Date of your last eye exam: _____

Women ONLY:

Date of your last mammogram: _____ Date of your last pap smear: _____

Number of pregnancies? _____

Current Medications *If you need more lines, please request another form.

☐ None

Name of Medication	Strength (mg)	How Often	Reason for Medication

Advanced Directives/Living Wills:

Do you have an advanced directive or a living will? ☐ Yes ☐ No

If yes, please give a copy to front desk.

If no, would you like more information? ☐ Yes ☐ No

Name of Person Completing Form: _____ **Patient Signature:** _____