NOVANT HEALTH

Patient Name:_____ **Date of Birth:** _____

Reason For Visit: _____

Preferred Pharmacy: _____

Present Medications: (If more space is needed please continue on back side of this paper.)

Medication Name	Strength	Directions
****If you are on oxygen, aspirn or any over the counter medication, please list it below******		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES:

- **Medication/Food:**_____ **Reaction:**_____
- **Medication/Food:**_____ **Reaction:**_____
- **Medication/Food:**_____ **Reaction:**_____

OB/GYN Status: FEMALES ONLY

Last Menstrual Period: _____ **Date of Last Mammogram:** ___/___/_____

____# of pregnancies ____ # of abortions____ # of miscarriages ____ # live of children

Breastfeeding? ___Yes ___No **Hysterectomy?** ___Yes ___No

Social History:

____Single ____Married ___Widowed ____Divorced ____Separated

Who do you live with? (name & relationship) _____

_____

Employed?: ___Yes ___No **Occupation:** _____

Do you have a living will? ____Yes ____No

Sexual History: ___Never had sex ___ Have sex with: ___Men ___Women ___Both

Drug/Alcohol/Tobacco Use:

Have you ever smoked? ____Yes___No **How many packs/day?**___ **How many Years?**___

Quit? ___Yes ___No **When?** ___/___/_____

Do you use any smokeless tobacco? ___Yes ___No **Quit?** ___/___/_____

Do you drink alcohol? ___Yes ____No **How many times/week?** ____

Quit? ___Yes ___No **When?** ___/___/_____

Do you use any street drugs? ___Yes ___No **If so what?** _____

Have you had your pnemonia vaccine? ___Yes ___No **If so when?** _____

Surgical History:

Surgery	Date	Location
Cataract		
Lasik		
Tonsillectomy		
Hysterectomy		
Heart Surgery		
Colonoscopy		
Hernia Repair		
Gall Bladder		
Tubal Ligation		
Orthopedic		
C-Section		
Other:_____		

Self/Family History:

	SELF	Mother	Father	Sister	Brother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Daughter	Son
Alcoholism															
High Blood Pressure															
Cancer															
COPD															
Arthritis															
Diabetes															
High Cholesterol															
Asthma															
Thyroid Disease															
Stroke															
Heart Disease															
Depression															
Emphysema															
HIV/AIDS															
Kidney Disease															
Other:_____															

*Mother Living? ___Yes ___No Cause of Death?_____

*Father Living? ___Yes ___No Cause of Death?_____