



New Patient/ Adult Physicals

Patient Name: _____ D.O.B. _____ Date: _____

Social History-

Married Single Divorced; # of children _____, Occupation _____

Tobacco use-

Never Social Packs per day- _____ for # years _____, Quit- year _____

Alcohol use- # of drinks _____ per Day Week Month **Marijuana/ Illicit Drug Use-** _____

Do you have any allergies to medication? Please list N/A

Have you had any previous surgeries? Please list N/A

Medical Problems/ History:

Family History: Please include the AGE it began—Heart issues, cancer (and type if known), stroke, hypertension, cholesterol, diabetes

Father _____ Mother _____

Paternal Grandmother _____ Maternal Grandmother _____

Paternal Grandfather _____ Maternal Grandfather _____

Paternal Aunt _____ Maternal Aunt _____

Paternal Uncle _____ Maternal Uncle _____

Siblings _____

Females Only:

Last Mammogram: _____

Last Pap: _____

Last Menstrual Period: _____

Birth Control: _____