NEW PATIENT HEALTH HISTORY FORM
ADULT

HUNTER HEALTH

BASIC INFORMATION

NAME	TODAY'S DATE
DATE OF BIRTH	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW / WIDOWER
WORK STATUS / OCCUPATION	PREFERRED PHARMACY
SEX AT BIRTH ☐ MALE ☐ FEMALE	GENDER IDENTIFICATION (ex. male, female, transgender, gender neutral, non-binary...)
SPECIALISTS / OTHER CARE PROVIDERS	

SURGERY (including any eye/ear surgeries and hysterectomy or breast procedures)

LIST ALL SURGERIES, INCLUDE YEAR (Note left-side or right-side, when applicable)

PAST AND PRESENT MEDICAL PROBLEMS (circle and describe)

CARDIOVASCULAR

HIGH BLOOD PRESSURE ☐
HIGH CHOLESTEROL ☐
PERIPHERAL ARTERY DISEASE ☐
HISTORY OF BLOOD CLOT ☐
HISTORY OF HEART RHYTHM DISORDER ☐
(describe)
HEART DISEASE (describe) ☐

NO PROBLEMS ☐

GASTROINTESTINAL

GERD ☐
DIVERTICULOSIS ☐
COLON POLYPS ☐
HEMORRHOIDS ☐
LIVER DISEASE (describe) ☐

BOWEL DISEASE (describe) ☐

NO PROBLEMS ☐

GENITOURINARY

RECURRENT UTI ☐
URINARY INCONTINENCE ☐
PROSTATE ENLARGEMENT ☐
KIDNEY STONES ☐
KIDNEY DISEASE (describe) ☐

GYNECOLOGIC DISEASE (describe) ☐

NO PROBLEMS ☐

EYES, EARS, NOSE, THROAT

CATARACT ☐
GLAUCOMA ☐
HEARING PROBLEM ☐
SINUSITIS, ALLERGIES ☐
DENTURES, IMPLANTS ☐
VISION PROBLEM (describe) ☐

NO PROBLEMS ☐

INFECTIOUS DISEASE

HISTORY OF CHICKEN POX / SHINGLES ☐
HISTORY OF TUBERCULOSIS ☐
HIV ☐
HEPATITIS A ☐ B ☐ C ☐
HISTORY OF MRSA ☐
NO PROBLEMS ☐

PULMONARY

ASTHMA ☐
COPD / EMPHYSEMA ☐
SLEEP APNEA ☐
NO PROBLEMS ☐

RHEUMATOLOGY

ARTHRITIS ☐
GOUT ☐
RHEUMATOID ARTHRITIS ☐
FIBROMYALGIA ☐
NO PROBLEMS ☐

ENDOCRINE

THYROID DISEASE LOW ☐ HIGH ☐
DIABETES ☐
OSTEOPOROSIS ☐
NO PROBLEMS ☐

NEUROPSYCHIATRIC

ANXIETY ☐
DEPRESSION ☐
BIPOLAR ☐
SEIZURES ☐
MEMORY PROBLEMS / DEMENTIA ☐
MIGRAINE ☐
NEUROPATHY ☐
SCHIZOPHRENIA ☐
HISTORY OF STROKE ☐
OTHER MOOD DISORDER (describe) ☐

NO PROBLEMS ☐

CANCER

TYPE / LOCATION

YEAR

TREATMENT SURGERY ☐ CHEMO ☐ RADIATION ☐
ONCOLOGIST
NO CANCER ☐

OTHER PROBLEMS

PLEASE LIST

NEW PATIENT HEALTH HISTORY FORM
ADULT

REVIEW OF SYMPTOMS (check all symptoms that you have had in the last few days)

GENERAL
- CHILLS
- FATIGUE
- FEVER
- NIGHT SWEATS
- WEIGHT GAIN / LOSS

NEUROLOGICAL
- DIFFICULTY SPEAKING
- FAINTING
- HEADACHE
- LOSS OF STRENGTH
- MEMORY LOSS
- SEIZURES
- TINGLING / NUMBNESS
- TREMOR

PSYCHOLOGICAL
- ANXIETY
- DEPRESSED MOOD
- DIFFICULTY SLEEPING
- MENTAL OR PHYSICAL ABUSE

EYE
- BLURRY VISION
- EYE PAIN

ENT
- RUNNY NOSE
- CONGESTION
- DIFFICULTY SWALLOWING
- EAR PAIN
- RINGING IN EARS
- SNORING
- SORE THROAT

ENDOCRINE
- COLD INTOLERANCE
- EXCESSIVE THIRST
- HAIR LOSS
- HEAT INTOLERANCE

RESPIRATORY
- COUGH
- SHORTNESS OF BREATH
- WHEEZING

CARDIOVASCULAR
- CHEST PAIN
- PAIN IN LEGS WHEN WALKING
- FLUID ACCUMULATION IN LEGS
- DIFFICULTY BREATHING WHEN LAYING FLAT
- PALPITATIONS

GASTROINTESTINAL
- ABDOMINAL PAIN
- BLOOD IN STOOL
- CONSTIPATION
- DIARRHEA
- HEARTBURN
- NAUSEA
- VOMITING

MUSCULOSKELETAL
- MUSCLE ACHES
- JOINT PAIN
- JOINT SWELLING

ALLERGY / IMMUNOLOGY
- IMMUNE DEFICIENCY
- SEASONAL ALLERGIES

HEMATOLOGY
- BLEEDING PROBLEMS
- EASY BRUISING

SKIN
- DISCOLORATION
- ITCHING
- CHANGE IN MOLES OR SPOTS
- RASH

URINARY
- BLOOD IN URINE
- DIFFICULTY URINATING
- KIDNEY PROBLEMS
- PAINFUL URINATION

BREAST
- LUMP
- PAIN
- NIPPLE DISCHARGE
- SKIN CHANGES

WOMEN
- PELVIC PAIN
- MENOPAUSAL SYMPTOMS
- GENITAL SORES / RASH
- IRREGULAR PERIODS
- VAGINAL DISCHARGE / ITCHING

MEN
- ERECTILE DYSFUNCTION
- PENILE DISCHARGE
- GENITAL SORES / RASH

OTHER

FAMILY HISTORY (List major health problems of blood relatives, if known. If deceased, list age at death.)

MOTHER	FATHER
SIBLINGS	CHILDREN
GRANDPARENTS	AUNT / UNCLE

CHECK IF YOUR FAMILY HISTORY IS UNKNOWN.

SOCIAL HISTORY (Checkmark/type details)

- SMOKING (# packs per day)
- eCIGARETTE / HOOKAH / VAPOR
- SNUFF / CHEW (# cans per day)
- ALCOHOL (# per week)
- STREET DRUGS:
  MARIJUANA / CBD / KRATOM
  (please list others)

- WHO DO YOU LIVE WITH?
- DO YOU FOLLOW A SPECIAL DIET?
- DO YOU EXERCISE?
- DO YOU SLEEP WELL?
- DO YOU HAVE ANY: ADVANCED DIRECTIVES / LIVING WILL / DURABLE POWER OF ATTORNEY

NEW PATIENT HEALTH HISTORY FORM
ADULT

SEXUAL / REPRODUCTIVE HISTORY (Please answer questions based on sex at birth.)

NUMBER OF BIOLOGICAL CHILDREN:

NUMBER OF ADOPTED CHILDREN:

ARE YOU CURRENTLY SEXUALLY ACTIVE? ☐

ARE YOUR PARTNERS: MEN / WOMEN / BOTH

HOW MANY SEXUAL PARTNERS HAVE YOU HAD IN THE LAST YEAR?

DO YOU USE ANY FORM OF CONTRACEPTION? ☐

IF YES, WHAT FORM?

HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE? ☐

IF YES, WHICH: HERPES / GONORRHEA / CHLAMYDIA / HIV
GENITAL WARTS / SYPHILIS / TRICHOMONAS

WOMEN

DO YOU HAVE PERIODS? ☐

FIRST DAY OF LAST PERIOD:

LENGTH OF PERIODS:

HOW OFTEN DO YOU HAVE A PERIOD?

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? ☐

IF YES, WHEN AND OUTCOME:

HOW MANY TIMES HAVE YOU BEEN PREGNANT?

NUMBER OF VAGINAL DELIVERIES:

NUMBER OF CESAREAN SECTIONS:

REASON?

NUMBER OF MISCARRIAGES:

NUMBER OF STILLBIRTHS:

NUMBER OF ABORTIONS:

NUMBER OF TUBAL / ECTOPIC PREGNANCIES:

ANY PROBLEMS WITH PREGNANCIES OR DELIVERIES? ☐

ANY PROBLEMS WITH POSTPARTUM DEPRESSION? ☐

MEN

HAVE YOU EVER BEEN DIAGNOSED WITH A PROSTATE ISSUE OR HAD A PROSTATE BIOPSY? ☐

DO YOU CURRENTLY STRUGGLE WITH STARTING, STOPPING, OR MAINTAINING A URINARY STREAM? ☐

DO YOU HAVE A HISTORY OF TESTICULAR OR TESTOSTERONE PROBLEMS? ☐

PRIMARY PREVENTATIVE CARE SCHEDULE

VACCINATIONS	DATE	WOMEN	DATE	MEN	DATE
TETANUS ☐		COLONOSCOPY ☐		COLONOSCOPY ☐	
INFLUENZA ☐		PAP SMEAR / HPV TESTING ☐		PROSTATE CANCER SCREENING (PSA) ☐	
PNEUMONIA 13 ☐		MAMMOGRAM ☐			
PNEUMONIA 23 ☐		BONE DENSITY ☐			
SHINGLES ☐					
HPV ☐					
COVID-19 ☐					
HEPATITIS B ☐					

WHEN WAS YOUR LAST DENTAL EXAM?

WHEN WAS YOUR LAST EYE EXAM?

MEDICATIONS

CURRENT MEDICATIONS (include dose and frequency) WRITE ON BACK IF NECESSARY.	MEDICATION ALLERGIES
PLEASE INCLUDE any Durable Medical Equipment such as **Oxygen, CPAP, BIPAP, etc.**	

PATIENT / GUARDIAN SIGNATURE DATE