Baptist Primary Care
New Patient Form

Name:_____

DOB: _____

Past History

Last pap smear:	Allergies: None List Allergies:
Last mammogram/ prostate exam: result:	
Last colonoscopy: Last eye exam:	# of children _____ # of pregnancies _____
Please List All Personal Illnesses/Injuries and approximate dates:	Please list all past surgeries with approximate dates:

Social History

Married   Single   Divorced   Widowed   Most recent occupation: _____

Smoker? Yes   No   How much? _____ packs/ day   How long? _____ / years   Date quit: _____

Alcohol? Yes   No   How much? _____/ day   When? _____ Caffeine (coffee, tea, colas) How much? _____/ day

Illicit drug use? None   Currently using: _____   Prior problem? Yes   No   explain:_____

Exercise? Yes   No   How often? _____

Family History

Check ONLY the boxes that are POSITIVE: Diabetes   Heart disease   High blood pressure   Stroke   TB   Cancer

                    Kidney disease   Anemia   Arthritis   Mental illness

Please explain any boxes that are checked: _____

_____

Mother: Living   Deceased/ cause: _____ Age: _____Brother(s) # ____ Living   Deceased/ cause:_____ Age: _____ Father

Living   Deceased/ cause: _____ Age: _____ Sister(s) # _____ Living   Deceased/ cause:_____ Age: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER, HERBAL SUPPLEMENTS, AND BIRTH CONTROL..

MEDICATION	DOSAGE/ FREQUENCY