Foothills Health & Wellness Center

Adult New Patient History

Name: _____ Date of Birth: _____ Date: _____

For Internal Use Only:

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

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

Please list the other doctors you see:

Please list previous PCP:

Please list any allergies:

Past Medical History: Please check all that apply ☐

____Acid Reflux	____High Blood Pressure	____Seizure Disorder
____Anxiety	____High Cholesterol	____Stroke
____Ashma	____Enlarged Prostate	____Seasonal Allergies
____Bipolar Disorder	____Heart Attack	____Substance Use/Alcoholism
____Blood Clot (DVT/PE)	____Heart Valve Problem	____Thyroid Problem
____Cancer	____Hepatitis	____Tuberculosis
____Chronic Pain	____Hemophilia (Free Bleeder)	Other:
____COPD	____Kidney Disease	Other:
____Coronary Artery Disease	____HIV/AIDS	Other:
____Crohn's Dis/Ulcerative Colitis	____Migraines	Other:
____Depression	____Peripheral Artery Disease	Other:
____Diabetes	____Rheumatoid Disease	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 member have had the following:

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

revised: 12/10/2024

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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. ☐ 1/2 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

Patient Signature: _____

Name of Person Completing Form: _____