New Patient (non-newborn) Profile:

Patient name: _____ Date of birth: _____ Today's date: _____
Patient's age: _____

Patient's Medical History:

	Yes	No	If yes, list below
Is patient under a physician's care now for any medical condition?	___	___	_____
Has patient ever been hospitalized or had a major operation?	___	___	_____
Has patient ever had a major head or neck injury?	___	___	_____
Has patient ever had any significant prior illnesses or injuries?	___	___	_____
Is patient presently taking any medications?	___	___	_____
Is patient presently on a special diet?	___	___	_____
Does patient have any allergies?	___	___	_____

Has patient ever been diagnosed with (or treated with) any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV	___	___	Frequent cough	___	___	Leukemia	___	___
ADHD	___	___	Frequent diarrhea	___	___	Liver disease	___	___
Anyphylaxis	___	___	Frequent headaches	___	___	Low blood pressure	___	___
Anemia	___	___	Genital herpes	___	___	Lung disease	___	___
Arthritis/Gout	___	___	Glaucoma	___	___	Psychiatric care	___	___
Asthma	___	___	Hay fever	___	___	Radiation treatment	___	___
Blood disease	___	___	Heart failure	___	___	Recent weight loss	___	___
Blood transfusion	___	___	Heart attack	___	___	Rheumatic fever	___	___
Breathing problem	___	___	Heart disease	___	___	Shingles	___	___
Bruising easy	___	___	Hemophilia	___	___	Sickle cell disease	___	___
Cancer	___	___	Hepatitis B	___	___	Sinus problems	___	___
Chemotherapy	___	___	Hepatitis A or C	___	___	Spina bifida	___	___
Chest pain	___	___	Herpes	___	___	Stomach/intestinal dz	___	___
Congenital heart disease	___	___	High blood pressure	___	___	Stomach ulcers	___	___
Diabetes	___	___	High cholesterol	___	___	Stroke	___	___
Drug addiction	___	___	Hives	___	___	Swelling of limbs	___	___
Emphysema	___	___	Hypoglycemia	___	___	STD	___	___
Epilepsy or seizures	___	___	Irregular heartbeat	___	___	Thyroid disease	___	___
Excessive bleeding	___	___	Jaundice	___	___	Tuberculosis	___	___
Excessive thirst	___	___	Joint disease	___	___	Tumors	___	___
Fainting spells/dizziness	___	___	Kidney problems	___	___			

Has patient ever had any serious illness not listed above? ___ Yes ___ No If yes, _____

Family History:

Does any family member have any disease that may be hereditary or place this patient at risk?
___ Yes ___ No

Father's name: _____ Present age: _____
Address: Street: _____ Apt.# _____
City: _____ State: _____ Zip: _____
Father's phone #: (H) _____ (C) _____ (W) _____
Father's place of employment: _____
Does father use tobacco? ___ Yes ___ No Is father in overall good health? ___ Yes ___ No
Is father deceased? ___ Yes ___ No If yes, cause of death: _____

Mother's name: _____ Present age: _____
Address: Street: _____ Apt.# _____
City: _____ State: _____ Zip: _____
Mother's phone #: (H) _____ (C) _____ (W) _____
Mother's place of employment: _____
Does mother use tobacco? ___ Yes ___ No Is mother in overall good health? ___ Yes ___ No
Is mother deceased? ___ Yes ___ No If yes, cause of death: _____

Siblings: Does patient have any siblings? ___ Yes ___ No If yes, give names below.

Name:		Health status:	Living or deceased?	Cause of death
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Has any family member (parent, grandparent, biological sibling, aunt or uncle) ever been diagnosed or treated with any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV	___	___	Frequent cough	___	___	Leukemia	___	___
ADHD	___	___	Frequent diarrhea	___	___	Liver disease	___	___
Anyphylaxis	___	___	Frequent headaches	___	___	Low blood pressure	___	___
Anemia	___	___	Genital herpes	___	___	Lung disease	___	___
Arthritis/Gout	___	___	Glaucoma	___	___	Psychiatric care	___	___
Asthma	___	___	Hay fever	___	___	Radiation treatment	___	___
Blood disease	___	___	Heart failure	___	___	Recent weight loss	___	___
Blood transfusion	___	___	Heart attack	___	___	Rheumatic fever	___	___
Breathing problem	___	___	Heart disease	___	___	Shingles	___	___
Bruising easy	___	___	Hemophilia	___	___	Sickle cell disease	___	___
Cancer	___	___	Hepatitis B	___	___	Sinus problems	___	___
Chemotherapy	___	___	Hepatitis A or C	___	___	Spina bifida	___	___
Chest pain	___	___	Herpes	___	___	Stomach/intestinal dz	___	___
Congenital heart disease	___	___	High blood pressure	___	___	Stroke	___	___
Diabetes	___	___	High cholesterol	___	___	Swelling of limbs	___	___
Drug addiction	___	___	Hives	___	___	Thyroid disease	___	___
Emphysema	___	___	Hypoglycemia	___	___	Tuberculosis	___	___
Epilepsy or seizures	___	___	Irregular heartbeat	___	___	Tumors	___	___
Excessive bleeding	___	___	Jaundice	___	___	Stomach ulcers	___	___
Excessive thirst	___	___	Joint disease	___	___	STD	___	___
Fainting spells/dizziness	___	___	Kidney problems	___	___			

Social History:

Primary household language spoken: _____
Grade in school: _____ School attending: _____
Is patient exposed to tobacco smoke or excess alcohol consumption in the home? ___ Yes ___ No
Patient lives with: ___ mother ___ father ___ both ___ Other: _____

	Yes	No
Does patient use tobacco, alcohol or controlled substances?	___	___
Is patient sexually active?	___	___
Is patient on oral contraceptives?	___	___
Has patient ever been pregnant?	___	___
Do you have concerns that this patient may be abusing drugs?	___	___
Is patient employed?	___	___ If yes, where? _____

Signature of parent/guardian completing this form _____ Date: _____
This form was reviewed on _____ by _____