SHORE PREVENTATIVE
WELLNESS CENTER

New Patient Forms

Name: _____ Age: _____ Date of Birth: ___/___/___

Address: _____

Sex *(circle one): M / F / Non-Binary / Trans_____ / Other*

SS#: _____-____-_____

Phone Number: _____ Home / Cell / Work
Emergency Contact Name/Phone: _____

Email address: _____

Occupation: _____

Marital Status *(circle one)*: Single / Married / Divorced / Widowed / Separated

If married, spouse's name: _____

Allergies to medications, X Ray dyes or other substances: Y / N
If yes, please list name of medication and types of reaction:

_____

Medical History and Review of Systems
Please circle if you had past problems with or are presently complaining of the following:

1. High Blood Pressure	**16. Hay Fever**	**31. Head or neck radiation**
2. Diabetes	**17. Abdominal Discomfort**	**32. Headache**
3. Cancer	**18. Indigestion**	**33. Kidney disease/Stones**
4. Heart disease	**19. Nausea**	**34. Difficulty urinating**
5. Chest Pain or Tightness	**20. Vomiting**	**35. Arthritis**
6. Shortness of Breath	**21. Constipation**	**36. Low Back Problems**
7. Swollen Ankles	**22. Diarrhea**	**37. Blood Disorders**
8. Palpitations	**23. Ulcers**	**38. Venereal Disease**
9. Frequent Urination	**24. Change in Bowel Habits**	**39. Asthma**
10. Rheumatic Fever	**25. Anxiety**	**40. Bronchitis**
11. Hemorrhoids	**26. Anemia**	**41. Pneumonia**
12. Gall Bladder Disease	**27. Alcohol Abuse**	**42. Persistent Cough**
13. Colitis	**28. Drug Abuse**	**43. Tuberculosis**
14. Hepatitis or Jaundice	**29. Gout**	**44. Abnormal Wt. Loss/Gain**
15. Thyroid disease	**30. Weight Loss or Gain**	

45. Other_____

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Gynecologic and Obstetric History

Age at onset of period: _____ Frequency: _____ Length: _____
Pregnancies: Y / N Births: _____ Miscarriages: _____
Prolonged or abnormal bleeding: No_____ Yes ____Describe: _____
Leakage of Urine: No _____Yes____ Describe: _____
Pelvic Pain: No _____ Yes____ Describe: _____
Abnormal Discharge: No ____ Yes____ Describe:_____
History of Abdominal Pap Smears No_____ Yes_____ Describe:_____

Surgeries

Please list any surgeries you have had:

Hospitalizations

Please list any hospitalizations that you have had:

Immunization History

Hepatitus B	**Yes / No**	**if yes, when: _____**
Pneumovax	**Yes / No**	**if yes, when: _____**
Flu	**Yes / No**	**if yes, when: _____**
Tetanus	**Yes / No**	**if yes, when: _____**
COVID-19	**Yes / No**	**if yes, when: _____**

Other: _____

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Family History

Has any member of your family (parents, grandparents, and siblings) ever had any of the following?

	List Family Member	Age at Diagnosis
Cancer (please list type)		
High Blood Pressure		
Heart Disease		
Diabetes (T1/T2)		
Strokes		
Anxiety / Depression		
Drug / Alcohol Addiction		
Glaucoma		
Bleeding Diseases		

Other: _____

Medications

Please list all medications and doses that you are currently taking (prescription/otc/vitamins):

Medication	Dose

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Prevention

1. **Do you use recreational drugs? Y / N**
2. **Do you wish to be tested for AIDS? Y / N**
3. **Have you been exposed to hazardous chemicals? Y / N**
4. **Do you smoke? Y / N if yes, how often? _____**
5. **Do you vape? Y / N if yes, how often? _____**
6. **Do you drink alcohol? Y / N if yes, how often? _____**
7. **Are you interested in speaking with a nutritionist? Y / N**
8. **Are you interested in speaking with a psychotherapist? Y / N**

_____ _____

Patient Name **Date**

_____

Patient Signature