

Ogden Internal Medicine

New Patient Packet

Patient Name: _____

Date of Birth: _____

PAST MEDICAL HISTORY:

Please list any significant illnesses for which you currently receive treatment or for which you have been treated in the past; when possible, list dates at which the illness began or was diagnosed, and if treatment was completed or the condition resolved.

Current or past Illness	Date Illness began or was diagnosed	Treatment completed or condition resolved Yes or No	Date Condition resolved

Please list all other Heathcare Providers:

Current Physicians	Specialty

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What are the reasons for scheduling this appointment:

Surgeries

Date	Surgery	Surgeon

Hospitalizations

Date	Reason	Hospital

Immunizations

	Date
Flu Vaccine	
Pneumovax	
Tetanus (what type)	
Shingles	

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Preventive Care/Health Care Maintenance:

If you are 50 years or older, have you had a colonoscopy? Date:
If yes, what were the findings?

If you are a female do you see an OB/GYN for PAP smears? Date:

If you are a female over 40, when was your last mammogram?

Have you had a Dexa (bone density) test? Date:

Social History:

Do you drink alcohol? Yes or No
If yes, how many drinks do you have per week?

Do you smoke? Yes or No
If yes, how much do you smoke per day?
If past smoker, when did you quit?

Do you drink caffeine? Yes or No
Coffee Soda Tea
If yes, how much caffeine do you drink per day?

Have you ever used street drugs? Yes or No
If yes, what type?

Do you exercise? Yes or No
If yes, how often and what type?

Marital Status:
Single Divorced Widowed Other

With whom do you currently live?

Do you have children? Yes or No
If yes how many?

What is your occupation?

Do you have pets? Yes or No

Have you ever traveled outside of the United States? Yes or No
If yes, where and when?

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Family History:

The following questions refer only to your immediate family: parents and siblings.

Has anyone in your family been diagnosed with cancer?

Who	Type of Cancer

Has anyone in your family been diagnosed with heart disease?
(heart attack, coronary artery disease, heart failure, arrhythmia)

Who	What type

If your parents are deceased, what were the causes of death and what age did they pass away?

Is there any other family medical history you think we should be aware of?