ProHealth™ PHYSICIANS
Part of OptumCare®

ProHealthMD.com

New patient health history form (page 1 of 3)

First name: _____ Last name: _____

Today's date: _____ Date of birth: _____

List any concerns you want to talk about during your visit: _____

_____

Health history:	
Do you have diabetes? ☐ Yes ☐ No High blood pressure? ☐ Yes ☐ No High cholesterol? ☐ Yes ☐ No	Do you have other health conditions? _____ _____

Social history:	
Do you smoke cigarettes?	☐ Never ☐ Yes _____ # packs/day ☐ Quit Date quit _____ Years smoked _____
Do you vape (e-cigarettes)?	☐ No ☐ Yes
Do you drink alcohol?	☐ Never ☐ Yes _____ # drinks per week
Do you use recreational drugs?	☐ Never ☐ Rarely _____# times per month ☐ Marijuana ☐ Cocaine ☐ Opioids ☐ Other_____
What is your highest level of education completed?	☐ High School ☐ Trade school ☐ College ☐ Post-graduate degree(s)
Are you employed?	☐ No ☐ Retired ☐ Yes Type of work_____
Do you exercise?	☐ No ☐ Yes Type _____ How often _____ How long per activity_____
What is your marital status?	☐ Married ☐ Partnership ☐ Divorced ☐ Separated ☐ Single ☐ Widow/er
Are you sexually active?	☐ No ☐ Yes # of sexual partners _____ ☐ Men ☐ Women ☐ Both Contraception: ☐ No ☐ Yes If yes, method _____
Do you have children?	☐ No ☐ Yes # of children _____ ages _____

Surgical history/recent hospitalizations: Date and type of surgery/procedure

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New patient health history form (page 2 of 3)

First name: _____ Last name: _____ Date of birth: _____

Family history:		
Relation	**Health conditions**	**Family history of cancer?**
Mother		If yes, list relative and type of cancer.
Father		
Children		
Brother/Sister		

Preventive care:			
Recent shots from a **non-ProHealth** doctor or pharmacist	☐ Flu	Date:	Place:
	☐ Shingles	Date:	Place:
	☐ Pneumonia	Date:	Place:
	☐ Tetanus	Date:	Place:
	☐ Other	Date:	Place:
Recent tests or procedures	☐ Colonoscopy	Date:	Place:
	☐ Cologuard/Stool card	Date:	Place:
	☐ Mammogram	Date:	Place:
	☐ PAP	Date:	Place:
Other:			

Specialists:		
Provider's first and last name	**Specialty**	**Town / City**

Medications:	**Allergies:**
Name / Dose / Times per day	**Type / Reaction**

Pharmacies:		
	Name	**Location**
Local		
Mail order		

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New patient health history form (page 3 of 3)

First name: _____ Last name: _____ Date of birth: _____

Symptoms: Please check any symptoms you have now or have had in the past month.

General	Heart/circulation	Musculoskeletal	Nervous System
☐ Fever	☐ Chest pain	☐ Joint pain	☐ Numbness
☐ Chills	☐ Heart pounding	☐ Neck pain	☐ Weakness
☐ Feeling poorly	☐ Fast pulse	☐ Joint swelling	☐ Dizziness
☐ Feeling tired	☐ Slow pulse	☐ Joint stiffness	☐ Fainting
☐ Weight gain	☐ Leg pain with exercise	☐ Muscle aches	☐ Confusion
☐ Weight loss	☐ Leg swelling	☐ Back pain	☐ Headache
Eyes	**Ear/nose/throat**	**Skin**	**Reproductive**
☐ Eye pain	☐ Earache	☐ Sores	☐ Erection problems
☐ Red eyes	☐ Loss of hearing	☐ Rash	☐ Lump in testicle
☐ Eyesight problems	☐ Nosebleeds	☐ Itching	☐ Discharge from penis
☐ Discharge from eyes	☐ Runny nose	☐ Change in a mole	☐ Breast lump
☐ Dry eyes	☐ Sore throat	☐ Unusual growth/spot	☐ Nipple discharge
☐ Itchy eyes	☐ Hoarseness		☐ Abnormal Pap smear
Breathing	**Gastrointestinal**	**Psychiatric**	☐ Irregular bleeding
☐ Coughing	☐ Stomach pain	☐ Thoughts of harm to self or others	☐ Bad cramps
☐ Wheezing	☐ Upset stomach/ vomiting	☐ Sleep problems	☐ Pelvic pain
☐ Shortness of breath	☐ Diarrhea	☐ Anxiety	☐ Pain during sex
☐ Trouble breathing during exercise	☐ Constipation	☐ Depression	☐ Vaginal discharge
☐ Trouble breathing while lying down	☐ Heartburn	☐ Change in personality	Last period _____
☐ Snoring	☐ Blood in stool	☐ Emotional problems	Last Pap smear _____
Blood	**Endocrine**	**Genital and urinary**	Mammogram _____
☐ Bleed easily	☐ Hot flashes	☐ Pain when urinating	Are you pregnant? ____
☐ Bruise easily	☐ Muscle weakness	☐ Abnormal urination	# of pregnancies _____
☐ Swollen glands in neck	☐ Voice changes	☐ Urinate often at night	# of babies delivered___
	☐ General weakness	☐ Genital sores	# of miscarriages/ abortions _____

List other symptoms:

_____

_____

_____

Provider signature: _____ Date: _____