Echelon-Health
medicine - fitness - nutrition

NEW PATIENT HISTORY

NAME: First _____ Middle Initial ___ Last _____

Preferred Name/Call Me _____

DATE OF BIRTH: ____/____/____ **SEX:** ☐**M** ☐**F**

ADDRESS: _____

_____

PHONE NUMBER(S):

Mobile: (____) _____

Alternate: (____) _____

E-MAIL: _____

PREFERRED DIGITAL COMMUNICATION

☐ Email ☐ Text ☐ Either/both

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone number: (____) _____

SHARE MY PRIVATE MEDICAL INFORMATION WITH:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Do not share my private medical information with anyone

Echelon-Health Concierge Medicine
16110 N. Florida Ave.
Lutz, FL 33549
813-415-2319

MEDICAL HISTORY:

☐ HYPERTENSION (HIGH BLOOD PRESSURE)

☐ DYSLIPIDEMIA (ABNORMAL CHOLESTEROL OR TRIGLYCERIDES)

☐ DIABETES ☐ STROKE ☐ CORONARY ARTERY DISEASE (PLAQUE)

☐ ARTHRITIS ☐ GLAUCOMA ☐ ASTHMA

☐ ANXIETY ☐ DEPRESSION ☐ TENDONITIS

☐ HYPOTHYROIDISM ☐ CANCER: TYPE _____

OTHER: _____

_____

_____

SURGICAL HISTORY/PROCEDURES (INCLUDE APPROXIMATE DATE)**:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HOSPTIALIZATIONS (EXCLUDING SURGERY/PROCEDURES ABOVE – INCLUDE DATE)**:**

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

☐ DO YOU OR ☐ DID YOU USE TOBACCO**?**

WHICH TYPE? ☐ CIGARETTES ☐ CIGARS ☐ SMOKELESS

IF YOU HAVE QUIT USING TOBACCO, HOW LONG DID YOU USE IT (APPROX. YEARS)? _____

HOW MANY ALCOHOLIC BEVERAGES DO YOU CONSUME IN A TYPICAL WEEK? _____

☐ I USED TO DRINK ALCOHOL BUT STOPPED IN _____

FITNESS AND NUTRITION PROFILE:

HOW MANY TIMES A WEEK DO YOU EXERCISE? _____

DO YOU EAT A WELL-BALANCED DIET? ☐ YES ☐ NO ☐ SOMETIMES

HOW MANY MEALS DO YOU TYPICALLY EAT IN A DAY? _____

ARE YOU CURRENTLY FOLLOWING A SPECIAL DIET? ☐ YES ☐ NO.

IF YES, PLEASE DESCRIBE _____

DO YOU HAVE ANY FOOD ALLERGIES OR INTOLERANCES? ☐ YES ☐ NO. IF YES, PLEASE DESCRIBE _____

HAVE YOU ☐ LOST OR ☐ GAINED 10 POUNDS UNINTENTIONALLY IN THE LAST 6 MONTHS?

FAMILY MEDICAL HISTORY:

☐ HYPERTENSION (HIGH BLOOD PRESSURE) ☐ DYSLIPIDEMIA (ABNORMAL CHOLESTEROL)

☐ CORONARY ARTERY DISEASE (PLAQUE)

☐ HYPOTHYROIDISM ☐ DIABETES ☐ STROKE ☐ GLAUCOMA ☐ ASTHMA

☐ ANXIETY/DEPRESSION ☐ ARTHRITIS ☐ CANCER: TYPE _____

OTHER: _____

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MOST RECENT:

ALL PATIENTS	**WOMEN ONLY**
PHYSICAL _____	MAMMOGRAM _____
COLONOSCOPY _____	PAP _____

IMMUNIZATION HISTORY – HAVE YOU RECEIVED OR DO YOU NEED:

TETANUS/DIPHTHERIA/PERTUSSIS BOOSTER	☐ HAD (YR:_____)	☐ NEED
HEPATITIS B VACCINE	☐ HAD (YR:_____)	☐ NEED
HEPATITIS A VACCINE	☐ HAD (YR:_____)	☐ NEED
PNEUMONIA VACCINE (NOT FLU SHOT)	☐ HAD (YR:_____)	☐ NEED
VARICELLA VACCINE (CHICKENPOX)	☐ HAD (YR:_____)	☐ NEED
SHINGLES VACCINE (SHINGLES)	☐ HAD (YR:_____)	☐ NEED
HPV VACCINE	☐ HAD (YR:_____)	☐ NEED
OTHER _____	☐ HAD (YR:_____)	☐ NEED

MEDICATIONS/VITAMINS/SUPPLEMENTS:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: _____

ADDITIONAL SPACE IF NEEDED:

MY OTHER PHYSICIANS (NAME, LOCATION, SPECIALTY):

Date:

Patient Signature (Parent/Guardian sign for minor child and print name)

Reviewed by Tommy McElroy, MD

Date: