

NEW PATIENT HISTORY

NAME: FIRST _____ MIDDLE _____ 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

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):

HOSPITALIZATIONS (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: _____

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: _____

PREFERRED PHARMACY: _____

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

ADDITIONAL SPACE IF NEEDED:

MY OTHER PHYSICIANS (NAME, LOCATION, SPECIALTY):

_____ **Date:** _____

Patient Signature (Parent or Guardian for Minor)

Reviewed by Tommy McElroy, MD

_____ **Date:** _____