CATALYST MEDICAL CLINIC — NEW PATIENT RECORD - Adults

NAME: _____

DOB: _____ SEX ☐ Male ☐ Female Cell Phone _____ Tobacco Use _____

REFERRED BY: _____ DATE _____ Alcohol Use _____

CURRENT MEDICAL PROBLEMS

List all medical problems and approximate time they began.

Problems Onset Date

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

List all medications you take (including non-prescription medication)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

CURRENT ALLERGIES or SENSITIVITIES

List anything you are allergic to and describe how it affects you.

_____

_____

_____

_____

WORK HISTORY

Are you currently employed? ☐ Yes ☐ No

☐ In Home ☐ Retired ☐ Disabled

Present type of work _____

In your work are you exposed to:

☐ Harmful toxins ☐ Extremes in temperature

☐ Heavy lifting ☐ Undue stress, pressure

☐ Other _____

HEALTH CARE PROVIDERS

What other health care providers have cared for you in the past five years?

Year Doctor / Provider City & State

_____

Procedures: Pap / Mammogram / Colonoscopy

Dates: _____ _____ _____

Do you have other concerns or problems? ☐ Yes ☐ No

_____

_____

_____

Signed _____ Date_____

FAMILY MEDICAL HISTORY

Health is:

Relative	Age(s)	Good	Poor	Deceased
Father	_____	☐	☐	☐
Mother	_____	☐	☐	☐
Brothers	_____	☐	☐	☐
Sisters	_____	☐	☐	☐
Spouse	_____	☐	☐	☐
Children	_____	☐	☐	☐

Illness(es) _____

_____

_____

Cause(s) of Death _____

_____

_____

Check if you or a member of your family have had the following illnesses or problems. List which family member.

☐ Allergies _____

☐ Asthma _____

☐ Eczema, Rashes _____

☐ Eye Problems _____

☐ Thyroid Problems _____

☐ Lung Problems _____

☐ Heart Diseases _____

☐ Cholesterol Problems _____

☐ High Blood Pressure _____

☐ Phlebitis _____

☐ Stomach or Intestinal Problems _____

☐ Liver Diseases _____

☐ Kidney Problems _____

☐ Diabetes _____

☐ Hereditary Diseases _____

☐ Cancer _____

☐ Anemia or Blood Diseases _____

☐ Epilepsy _____

☐ Anxiety / Depression _____

☐ Alcohol / Drug Problem _____

☐ Snoring / Sleep Problem _____

☐ Daytime Drowsiness _____

☐ Other _____

History Updated / Date