

First Appointment

You can complete the highlighted fields on this form online and then print the form for easy reference. Only text that is visible on the form is printed; scrolled text will not print. Any text you enter into these fields will be cleared when you close the form; you cannot save it.

Print this form and fill in the information if you are seeing this health professional for the first time. Although you may have to complete a similar form when you arrive at the office, completing this form will help you organize your thoughts and provide more complete information.

Complete Section 2 at the end of your appointment if you have a health problem that needs treatment.

Section 1: Current health and health history

Reason for appointment

Why did I make this appointment?

Am I having any symptoms? Describe them. If pain is one of my symptoms, include where it is, how it feels, and how severe it is.

Has there been a recent change in my normal routine (for example, sleeping, eating, recent death of a loved one, divorce)?

Questions for women

Am I pregnant?	Yes	No	When was my last menstrual period?
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At what age did my menstrual cycles begin?	My cycles are:	Regular	Irregular
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When was my last mammogram?

If the results were abnormal, explain:

When was my last Pap smear?

If the results were abnormal, explain:

When was I last screened for colon cancer (if I am older than 50)?

If the results were abnormal, explain:

Questions for men

When was my last prostate examination (if I am older than 50 and younger than 75)?

If the results were abnormal, explain:

When was I last screened for colon cancer (if I am older than 50)?

If the results were abnormal, explain:

Immunization history

Immunization	Date last received	Immunization	Date last received
Influenza		Hepatitis B	
Pneumococcal		Shingles	
Tetanus (Td and Tdap)		Other	

Health history

Fill in your current health problems, such as poor eyesight or diabetes, and the name of the health professional you see for each problem.

Health problem	Health professional

Hospitalizations

Fill in the information for each time you have been in the hospital. Include any surgeries you have had on an outpatient basis.

When was I there? (date or year)	Why was I in the hospital?	Who was my doctor?	What hospital was I in?

Allergies

Fill in the following information if you have allergies to medicines or other substances.

Medicine or other substance	My reaction

Family history

List family members (parents, brothers, sisters, grandparents) who have or had the following major conditions.

Health condition	Relative (parent, brother, sister, grandparent)	Age, if living	Age at death	Comments
Heart problems				
Kidney disease				
Lung disease				
Depression or other major mental health condition				
Diabetes				
Breast cancer				
Colon cancer				
Other cancer or inherited disease				

Tobacco and alcohol use

I have never used tobacco products (cigarettes, pipes, cigars, or chewing tobacco).

Fill in the following information if you currently use or have ever used tobacco products.

Product (cigarettes, pipe, cigars, or chewing tobacco)	How much am I using now, or how much did I use before I quit? (for example, 1 pack of cigarettes a day or 1 cigar about once a week)	How long has it been since I quit?

How many days a week do I drink alcohol?

How many alcohol drinks do I typically have when I drink?

What are the risks and benefits of medicine, surgery, or other treatment? Fill in the following information about the treatment your health professional recommends for this condition.	
What are the chances that the treatment will work?	
What are the risks associated with the treatment?	
What might happen if I delay or avoid treatment?	
How soon will I see results of the treatment?	
What other treatment options are available?	
Do I need a medical test or X-ray? Yes No If yes, fill in the following information.	
What is the name of the test?	
Will the test results change the treatment? If yes, explain:	
How do I get the test results?	
What home treatment can I do? Ask the following questions about what you can do to help treat your condition.	
What do I need to change? How?	
Eating:	
Sleeping:	
Exercise:	
Other:	

What home treatment do I need to add? (for example, using a humidifier)

Do I have concerns about being able to carry out my part of the treatment? Yes No
If yes, discuss them with your health professional now.

Where can I get more information about this problem or the treatment?

How soon do I need to make a decision about getting a test or starting treatment?

What signs and symptoms should I watch for?

When should I call to report signs and symptoms?

Is there a chance that someone else in my family might get the same condition?

When should I contact my health professional? Fill in the appropriate box below with the date and time, if needed.

Check here if no contact is needed.	Call for test results or to report how I am doing:		Return for an appointment:	
		Date:	Time:	Date:

Reminder

Bring to your appointment all your medicines or a list of all the medicines you are taking.