Longs Peak Family Practice

NEW PATIENT INFORMATION SHEET

Name: _____ Date of Birth: _____Date: _____

Please answer all questions accurately and completely.

List ALL diseases you are presently receiving treatment for, and any serious illnesses you have had in the past:

_____

_____

List ALL medications you presently take regularly or occasionally, prescription, and non-prescription. Include dose and frequency: _____

_____

Are you allergic to any medications? Please list them plus your reaction:

_____

Have you ever been hospitalized/had an operation? List date(s), reason(s), and treatment(s):_____

_____

Date of your last dilated eye exam: _____ Date of your last dental exam: _____

How many alcoholic beverages do you consume in a: week? _____ month?_____
Do you smoke or chew tobacco/vaping? YES/NO If so, how much? _____
How much caffeine do you consume per day?_____
What illnesses/diseases are in your family?

Mother: _____
Father: _____
Siblings: _____
Other: _____

Are you married? YES/ NO If so, how long have you been married? _____

Circle the highest form of education you've received:

Elementary School High School College Graduate School

Present Occupation: _____
Religious affiliation: _____

Are you sexually active? YES/NO Please circle who you are sexually active with. M/F/Both

If yes, what method of birth control do you use if any?_____

FEMALES ONLY:

Age of your first period: _____ Date of last menstrual cycle: _____
Have you gone/are going through menopause? YES/NO If yes, what age did you start menopause? _____
Have you ever had an abnormal pap smear? YES/NO If yes, please list the date, abnormality (if known), and any follow up tests/procedures. _____
Have you ever had an abnormal mammogram? YES/NO If yes, please list the date, abnormality (if known), and any follow up tests/procedures. _____

If applicable, please list number of:

Pregnancies___ Full term deliveries___ Abortions___ Miscarriages/stillbirths___ Living children___