NEW PATIENT PAPERWORK- The Winston Clinic, P.A.

1) Tobacco/Nicotine Status: (circle one) **current** **former** **never**

Circle which type: **cigarette** **cigar** **smokeless tobacco** **vape**
If you circled one of the above: How many packs/items per day? _____
What year did you start? _____ What year did you quit? _____
Years smoked? _____ Exposed to second-hand smoke? ___YES ___NO

Do you use a VAPE? _____ YES _____ NO

2) HIV high risk behavior? ___YES ___NO

3) How many caffeinated beverages do you have daily? (tea, soda, coffee) __________**beverages daily**

4) Has your biological mother suffered a heart attack **before age 65?** ___ YES ___ NO

5) Has your biological father suffered a heart attack **before age 55**? ___ YES ___ NO

6) Do you exercise? ___ Yes ___ NO If YES:

How many times weekly? ______ What type of exercise? (cardio, weights, yoga, etc.) __________________

7) How often do you wear your seatbelt? (circle one) **100%** **75%** **50%** **25%** **0%**

8) Are you exposed to the sun? (circle one) **Frequently** **Occasionally** **Rarely** **Remotely**

9) Do you drink alcohol? ___ YES ___ NO

IF YES: On average: How often do you have drink alcohol? (Circle one)
-**Monthly or less** **2-4 times/month** **2-3 times/week** **4 or more times/week**
How many standard drinks of alcohol do you have in a typical day? _________
How often do you have 6 or more alcoholic drinks on one occasion? (Circle one)
- **Less than monthly** **Monthly** **Weekly** **Daily Or Almost daily**

10) Illegal drug use? ___ YES ___ NO

If yes was checked, what type? ____

Preventative measures:	**DATE**	**DOCTOR/FACILITY**
Last Pap Smear	________________________	____
Last Colonoscopy	________________________	____
Last Mammogram	________________________	____
Last annual labwork	________________________	____

PAST SURGERIES/PROCEDURES

APPROX DATE	**PAST SURGERIES**	**DOCTOR/FACILITY**

PAST MEDICAL HISTORY

11) Have you been diagnosed with any of the following? (please circle)

Anemia	Colon Cancer	Hepatitis C	Rheumatoid Arthritis
Anxiety	Other Cancer (please	High Cholesterol	Seizure Disorder
Asthma	list):____________	High Blood Pressure	Thyroid Problems
Atrial Fibrillation	Heart Disease	Thyroid Problems	Tuberculosis
Autoimmune Disorder	Crohn's Disease	Kidney Stone	Recurrent UTI
Liver Disease	Blood Clots	Heart Attack	Hysterectomy
Brain Tumor	Depression	Neurological Disorder	Other:________________
Breast Cancer	Diabetes	Osteoarthritis	_____________________
Chronic Kidney Disease	Diverticulitis	Osteoporosis	_____________________
Stroke	Acid Reflux	Gastric Ulcers	_____________________
Cerebrovascular Disease	Hepatitis A	Peripheral Vascular	_____________________
Cirrhosis	Hepatitis B	Disease	_____________________

12) Have you had any problems with anesthesia? ____YES ____NO

13) Please list any prescription and OTC medications you are currently taking or provide list.

Medication	**Strength**	**How often?**	**Why?**
(Example) Lisinopril	*10mg*	*1 daily*	*high blood pressure*

14) Please list any drug allergies and what reaction you have. Include food allergies, latex and dye allergies.

Allergy	**Reaction**	**Allergy**	**Reaction**

15) Do you see any other doctors? (Cardiology, Pulmonology, Urology, etc.) Please list below.

Name	**Specialty**	**Facility**

16) Who was your last Primary Care Provider & where are they located? Please list phone number if possible.

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