Date:______________________

SUNTREE INTERNAL MEDICINE

New Patient Information

Name:	**Date of Birth:**
Reason for visit:	**Occupation:**
Marital Status (circle): Married /Single/Widowed /Divorced /Separated **Any religious or cultural preferences you would like us to know**: ___________________________ **What gender do you identify with (circle):** Male/Female/Transgender **Alcohol Use:** Y/N how much/day____________________ **Caffeine Use**: Y/N how much/day____________________ **Recreational Drug Use (drug/how often)**: Yes/No___________________________	**Drug Allergies:**______________________________ ______________________________ **Food Allergies:**______________________________ **Sexual Orientation (circle):** Heterosexual/Homosexual/Bisexual Other:______________ **Exercise:** None OR Exercise type:____________________ ________________days/week ______________minutes/day **Diet Type:** ______________________________ **Current Health Status (circle):** Excellent/Good/Fair/Poor
Tobacco Use: Y/N how much/day____________________ **Are you interested in quitting:** Yes/No **Quit year**:________**Packs/Day**______**# of Years**________	**Past Medical History:**

Surgical History:

Past Medical History:

Family History: Please Note Condition /Relation

Cancer (type):
Diabetes:
Heart Disease:
Hypertension:
Other:

Current Medications Prescribed and OTC to include vitamins, herb, supplements:

Preventative Care:

Last Physical:
Last Eye Exam:
Last Pap Smear (women):
Last Mammogram (women):
Last Dexa Scan:
Last Dental Exam:
Last Colonoscopy:
Last lab work/where:

Specialists Seen/For What Condition:

Immunizations:

Flu:
Pneumonia :
Last Tetanus:
Other:

Preferred Pharmacy: Name:____

Address:____ Phone #_______________________________

How did you hear about us?____

Patient Signature___________________________________ Date________________________________