New Patient
Provider: _____
Appointment Date: _____

Cassopolis
Family Clinic Network
Our Family. Caring For Yours.

Medical and Family History

Patient's Legal Name: _____ Today's Date: _____

Sex at Birth: { } Female { } Male Date of Birth: _____ Phone Number: _____

Name of Primary Care Provider: _____ Phone: _____

Date of last physical exam: __/__/____ Are your immunizations up to date? { } Yes { } No { } I don't know

Year of last tetanus shot: __/__/____ Height: _____ Weight: _____

Are you now under the care of a physician? { } Yes { } No If yes, for what reason? _____

Allergies? (Please list all)

_____

_____

Are you presently taking any medications/prescriptions/over the counter/herbal/supplements? { } Yes { } No If yes, please list:

Medication	Dose	Frequency

What pharmacy do you prefer to use? _____ Pharmacy Phone: _____

Advanced Directives

Do you have a Power of Attorney? { } Yes { } No Would you like more information? { } Yes { } No

Do you have a Living Will? { } Yes { } No Would you like more information? { } Yes { } No

Have you had any serious illnesses, hospitalizations or accidents? { } Yes { } No

If yes, please explain: _____

_____

_____

Patient Health History

Do you currently have or have you ever had any of the following: Please circle Yes or No

Anemia	Yes	No
Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Blood Transfusion	Yes	No
Cancer	Yes	No
Cataract	Yes	No
Congestive Heart Failure	Yes	No
Clotting Disorder	Yes	No
COPD	Yes	No
Depression	Yes	No
Diabetes Mellitus	Yes	No

Emphysema	Yes	No
GERD	Yes	No
Glaucoma	Yes	No
Heart Murmur	Yes	No
HIV/AIDS	Yes	No
Hypertension	Yes	No
Kidney Disease	Yes	No
Meningitis	Yes	No
Myocardial Infection	Yes	No
Nerve / Muscle Disease	Yes	No
Osteoporosis	Yes	No
Seizures	Yes	No

Sickle Cell Anemia	Yes	No
Stroke	Yes	No
Substance Abuse	Yes	No
Thyroid Disease	Yes	No
Tuberculosis	Yes	No
Other:		
Have you had a positive Tuberculosis test?	Yes	No
If yes, when?		

Patient Surgical History

Have you had any of the *following* procedures or surgeries?
(Please circle Yes or No If yes, when)

Appendectomy	Yes	No	When:
Brain Surgery	Yes	No	When:
Breast Surgery	Yes	No	When:
CABG Surgery	Yes	No	When:
Cholecystectomy	Yes	No	When:
Colon Surgery	Yes	No	When:
Cosmetic Surgery	Yes	No	When:
C-Section	Yes	No	When:
Eye Surgery	Yes	No	When:
Fracture Surgery	Yes	No	When:
Hernia Repair	Yes	No	When:
Hysterectomy	Yes	No	When:
Joint Replacement	Yes	No	When:
Small Intestine Surgery	Yes	No	When:
Spine Surgery	Yes	No	When:
Tubal Ligation	Yes	No	When:
Valve Replacement	Yes	No	When:
Other:			When:
			When:
			When:
			When:

Family History

Check all boxes that apply:

	Alcoholism	Arthritis	Asthma	Cancer	Depression	Diabetes	Hypertension	Stroke
Father								
Mother								
Brother								
Sister								
Son								
Daughter								

Social History

Alcohol Use

{ } Yes { } No If yes: Type used: _____ How much per week: _____

Tobacco Use

{ } Yes { } No If yes: Type used: _____ How much per week: _____

Substance Use

{ } Yes { } Not Currently { } Never If yes: Type used _____

When Used: _____ When Stopped: _____

Sexual Orientation

Gender Identity: { } Male { } Female

{ } Transgender Male / Female-to-Male { } Transgender Female / Male-to-Female

Sexual Orientation: { } Lesbian or Gay { } Straight { } Bisexual { } Something Else { } Don't Know