Family Medicine in Kirkwood

Edward C. Chen, MD, Kevin P. King, MD,
Alexander W. Meyer, DO
10700 Manchester Road Suite D
Kirkwood, MO 63122
Ph:314-822-6830 Fax:314-822-6859

New Patient Health History Form <<CONFIDENTIAL>>

First _____ **MI**_____ **Last** _____ **Date of Birth** _____

Current Medications	Dose	Times per Day	Medication	Dose	Times per day
1			6		
2			7		
3			8		
4			9		
5			10		

Over the counter / Herbals / Supplements?	

Allergies (reaction?):	

Medical Problems (include date):		**Surgeries** (include date):
1	6	1
2	7	2
3	8	3
4	9	4
5	10	5

Social History.
Employment / Occupation _____Single □ Married □ Divorced □ Widowed □ Partner□
Children (ages)? _____ Who lives with you? _____

	Yes	No	
Smoking	□	□	Packs per day_____ Age started_____ Age quit_____
Alcohol	□	□	Drinks per week_____Type_____
Recreational Drugs	□	□	How often_____Type_____
Caffeine	□	□	Drinks per day_____
Sexually active	□	□	Partner (Male/Female)_____
Concerns about STDs	□	□	_____
Wear seatbelt	□	□	
Smoke detector at home	□	□	
Exercise	□	□	How often?_____Type_____
Special Diet	□	□	Type_____
Advanced Directive	□	□	_____
Power of Attorney	□	□	Who_____
Living Will	□	□	_____

OBGYN History (females) Number of times pregnant_____ Number of deliveries_____
Dates_____ C-section / vaginal_____
Last Menstrual Period _____Age Periods Started_____Age Periods Ended_____
Birth Control_____ Other_____

New Patient Health History Form <<CONFIDENTIAL>> Page 2

First _____ **MI**_____ **Last** _____ **Date of Birth** _____

Health Maintenance

Vaccine	Date(s) of last immunization
Tetanus or TDAP	
Influenza (flu)	
Pneumococcal	
HPV	
Hepatitis	

Family History

Disease	Yes	No	Relation / Age / Details
Diabetes			
High blood pressure			
High cholesterol			
Heart disease / attack			
Stroke			
Cancer			
Thyroid			
Kidney Disease			
Liver Disease			
Mental Illness			
Asthma			
Seizures			
Bleeding problems			
Other			

Labs / Exams	Date(s)	Result?
Cholesterol (lipids)		
Glucose (diabetes)		
Colonoscopy		
Dentist		
Eye Doctor		
Men Only		
PSA / Prostate		
Women Only		
Pap Smear		
Breast Exam		
Mammogram		

Patient Signature _____ Date_____