Northway Medical Assoc. New Patient / Patient History Form

Name:____

DOB:______________Cell:_______________Home:___________

Address: ____

Email Address:______________________________________

Sex: Female_____Male_____Other______

Insurance:____

Provider requested: Dr.Saini__Brittany Todd PA-C___Dr.Bair___

Melissa Rogers FNP___Sarah Oddo PA___

How did you hear about us?____________________________

____

Current Meds

____

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Previous PCP:____

Specialists/why:____

<u>Current medical problems:</u>

<u>Health Maintenance (Last year you had done) :</u>

Breast Exam- Pap/Pelvic Exam-

Colonoscopy- Dental Exam-

Eye Exam- Mammogram-

Do you wear your seatbelt ? Yes ____ No ____

# of Births- # of Pregnancies-

Premature_________ Fullterm_________ Abortions_________

<u>Surgical History(Date of surgery/Procedure/ Name of surgery)</u>

<u>Family history: (Medical Problems & If Deceased Please Specify Age/ How)</u>

Mother:

Father:

Sister:

Brother:

Grandparents:

<u>Occupation:</u>

<u>Tobacco Usage:</u>

Former smoker/ Yes______ No _______/ Year of quitting ___________

Current smoker/Yes______ No_______/ Years smoked_________

Vaping__ Cigarettes__ Cigars__ Chewing Tobacco___ Recreational/Medical Marjuanna___

<u>Alcohol Consumption: Wine/Liquor/Beer(check one for each row)</u>

Wine: Occasional____ Never____ Days out of week________/7

Liquor: Occasional____ Never____ Days out of week________/7

Beer: Occasional_____ Never _____ Days out of week________/7

Caffeine Consumption: Cups/Pots/Number of energy drinks daily

Hot Tea______ Hot Coffee______ Iced Tea______Iced Coffee_______

Energy Drinks______

Vaccinations received:

Shingles______ Covid______ Pneumonia______Flu_____

RSV_______Tetanus_______