WELLSTAR
Northwest Georgia Oncology Centers
A Service of WellStar Cobb Hospital

NEW PATIENT HEALTH HISTORY FORM

Patient Name:______________________________________ Birth Date___/___/______Today's Date___/___/______

Referring Physician:________________________________ Other Physicians you see:________________________________

____

Reason for visit: ____

____

Check any conditions you have:

Illness	Y	N	Diagnosis Year	Illness	Y	N	Diagnosis Year
High Blood Pressure				Kidney problem			
Bypass or Valve replacement				Stomach problem			
Pacemaker or Defibrillator				HIV			
Congestive Heart Failure				Hepatitis			
Heart Attack or rhythm problems				Osteoporosis			
Thyroid problem				Seizures			
Diabetes				Blood clots			
Asthma or COPD				Prior history of cancer			
Gout				Depression			

Other illness not listed above____

Prior Surgeries:

Procedure	Y	Year	Procedure	Y	Year	Procedure	Y	Year
Gallbladder			Spleen			Colon		
Uterus			Lumpectomy			Joint replacement		
Ovaries(one)			Mastectomy			Prostate		
Ovaries (both)			Stomach Bypass					

Health Maintenance: Fill in all that apply

Procedure	Date	Procedure	Date
Colonoscopy		Prostate Exam	
Mammogram		Pap Smear	

Gynecologic History: Fill in all that apply

First menstrual period age? ______ Last menstrual period (menopause) age? _______ Number of pregnancies ______

Birth control pills ☐ Yes ☐ No Hormone replacement therapy ☐ Yes ☐ No

Patient Name____**DOB**_________________________

Social History:

Tobacco Use ☐ **Yes (Please explain below)** ☐ **No and Never have**

Type	**Packs per day/How Often?**	**How many years?**	**Type**	**How Often?**	**How many years?**
Cigarettes			Cigar		
Pipe			Chewing tobacco		

Do you drink alcohol? ☐ **No** ☐ **Yes** ☐ **Occasionally** ☐ **Daily** ☐ **Beer/Wine** ☐ **Hard Liquor**

Marital Status: **Please circle one** **Single** **Married** **Life Partner** **Divorced** **Widowed**

Occupation__________________________________

Family History:

Family Member	**Alive**	**Deceased**	**Age**	**List Illnesses or Cause of Death**
Mother				
Father				
Siblings (brother/sister)				
Other:				

Are you allergic to any medications? ☐ **Yes** ☐ **No** **Please list:**____

____

Medications: List all medicines and supplements you take:

Name	**Start Date**	**Dose**	**How often?**	**Reason**

____

Patient Signature **Date**