Quality Healthcare Clinics
New Patient Form

Sparta Community Hospital

Patient Name: _____

Date of Birth: _____

FAMILY HISTORY

Fill in the appropriate boxes to identify ALL illnesses or condtions which you know have occurred in your *blood relatives* (Leave blank if you are unsure)	Self	Child	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
High Blood Pressure										
High Cholesterol										
Blood Problems/Abnormal Bleeding										
Anesthesia complications										
Lungs (includes bronchitis, pneumonia)										
Asthma										
Tuberculosis (TB)										
Diabetes										
Thyroid Problems										
Joint Disease (arthritis)										
Liver Disease										
Hepatitis										
Kidney Disease										
Bowel Disease										
Headaches										
Seizure Disorder										
Strokes										
Learning Disorder/ADD/ADHD										
Growth Problems										
Anxiety										
Depression										
Psychiatric Illness										
Suicide (or attempted suicide)										
Genetic Disorder										
Obesity										
Unexplained death										
Drug Abuse										
Alcohol Abuse										
Colon Cancer										
Breast Cancer										
Lung Cancer										
Other Cancers										
Other (discuss with provider)										

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Please circle any illnesses or conditions that YOU have had:

Hay Fever/ Allergies	Dizzy of Fainting Spells	Weight-loss/Weight Gain
Decreased Hearing	Memory Loss	Diarrhea/Constipation
Ringing in ear	Numbness/Tingling	Bone Fracture/Joint Injury
Failing Vision	Heart murmur	Gout
Prolonged Hoarseness	Blood Transfusions	Foot Pain
Chronic Fatigue	Kidney Stones	Other (discuss with provider)
Sleeping or concentration difficulty	Gallbladder Trouble	

Please list the date of which you have had any of the following:

Colonoscopy

Influenza Vaccine

Pneumonia Vaccine

Tetanus Vaccines

Females Only:

Mammogram

Pap smear

SOCIAL HISTORY

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

How many children do you have? _____ ☐None

Do you have any vision problems that affect your communication? ☐Yes ☐ No

Do you have any hearing problems that affect your communication? ☐Yes ☐ No

Do you have any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter

☐ Skilled Nursing Facility ☐ Other: _____

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____

Alcohol: ☐ Current ☐ Past ☐ Never # Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Sexual Orientation: ☐Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Unsure

Gender: ☐ Prefer not to disclose ☐ Identifies as Male ☐ Identifies as Female

☐ Female-to-Male (FTM)/Transgender Male/Trans Man

☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

☐ Genderqueer, neither exclusively Male nor Female

Are there any personal problems or concerns at home, work, or school that you would like to discuss?

☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

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SURGICAL HISTORY

Please list the date of which you have had any of the following:

Tonsillectomy and/or adenoidectomy

Myringotomy (ear tube surgery)

Cataract Removal

Joint Replacement

Hernia Repair

Fracture Repair

Heart Bypass surgery (CABG)

Other Heart Surgery

Gallbladder Removal

C Section

Hysterectomy

Please list any other surgical procedures: