BERKELEY FAMILY PRACTICE
New Patient Initial Visit

Name:_____ Date of Birth: _____ Age:_____ Date of Visit: _____
Name of Previous Doctor and Phone Number: _____
Preferred Pharmacy Information: _____

PAST MEDICAL HISTORY

Please circle any of the following that you have.

Anemia	Anxiety	Asthma
Bipolar Disease	Blood Clots	COPD
Depression	Diabetes	Heart Disease
Heart Failure	Hepatitis	Hypertension
High Cholesterol	Kidney Disease	Liver Disease
Lupus	Osteoarthritis	Rheum Arthritis
Seizure Disorder	Stroke	Seasonal Allergies
Thyroid Disease	Cancer *Type:* _____ *Age:* _____	

Please list other diagnoses not listed above:

- ☐ _____ ☐ _____
- ☐ _____ ☐ _____
- ☐ _____ ☐ _____

ALLERGIES

- ☐ No known drug allergies
- ☐ _____
- ☐ _____
- ☐ _____

HOSPITALIZATIONS

Date	Reason

SURGERIES

Date	Reason

OBGYN HISTORY

Last Menstrual Period? _____
Menopausal? _____
Total Number of Pregnancies: _____

FAMILY HISTORY

Please list any medical problems of the following family members (see list above).

Father	Alive/Deceased	
Mother	Alive/Deceased	
Paternal Grandfather	Alive/Deceased	
Paternal Grandmother	Alive/Deceased	
Maternal Grandfather	Alive/Deceased	
Maternal Grandmother	Alive/Deceased	
Sibling(s)	Alive/Deceased	
Children	Alive/Deceased	

SOCIAL HISTORY

Please circle status most application to you:
Single Married Separated Divorced Widow/Widowerer

What is your occupation?
_____

Do you or have you used tobacco products? **YES** or **NO**

- If **YES,** please answer the following:
  - Packs per day: _____
  - How many years have you smoked: ____
- If **NO,** please answer the following:
  - Have you ever smoked: _____
  - If so, how many packs per day: _____
  - How many years did you smoke: _____
  - When did you quit: _____

Do you drink alcohol? **YES** or **NO**

- If **YES,** please answer the following:
  How many drinks per day:_____
  Type of drink: _____

Any current or previous use of any drugs such as marijuana, cocaine, heroin, etc.? **YES** or **NO**

- If **YES,** please answer the following:
  Type of drug(s): _____
  Frequency: _____ How long: _____

PLEASE TURN PAGE TO LIST ALL DAILY MEDICATION AND SUPPLEMENTS

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CURRENT MEDICATIONS		
Drug Name	**Dose**	**How many times per day**

Please use the bottom of this form to add any pertinent information you feel your provider may need to know:

_____
_____
_____
_____
_____
_____
_____
_____