CHERRY
INTERNAL
MEDICINE

NEW PATIENT DEMOGRAPHICS

PATIENT INFORMATION	
Full name:	
Date of birth:	
Age/ Sex:	
Social Security No:	
Employment status:	
Address:	
City:	
State/ Zip Code:	
Home phone:	
Cell phone:	
Work phone:	
Marital Status:	
Race (optional):	
Preferred language:	
Emergency notification contact:	
Emergency notification phone:	
Relationship of emergency contact:	
Preferred pharmacy:	

INSURANCE INFORMATION	
PRIMARY:	SECONADARY:
Member number/ID:	Member number/ID:
Group name/number:	Group name/number:
Address:	Address:

Patient name: DOB:

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NEW PATIENT HEALTH HISTORY

MEDICATIONS AND SUPPLEMENTS *(Attach sheet if necessary)*			
Name	Dose	Times per day	Prescriber

ALLERGIES	
Medication	Reaction

HEALTH MAINTENANCE SCREENING			
	Date	Result	Facility/Provider
Colonoscopy			
Pap smear			
Mammogram			
Bone density			
PSA			
CT chest			
HIV screen			
Hepatitis C screen			
Abdominal ultrasound			
Last physical			

Patient name: DOB:

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VACCINATIONS	
	Date
Flu vaccine:	
Pneumovax:	
Prevnar13:	
TdaP (*Tetanus*):	
Shingrix/Zostavax (*Shingles*):	
HPV:	
Covid-19:	

SURGERIES		
Type *(specify side)*	Date	Facility/Provider

WOMEN'S HEALTH HISTORY	
Age of first menstruation:	
Date of last menstrual cycle:	
Number of pregnancies:	
Number of live births:	
Pregnancy complications:	
Age of menopause onset:	
History of abnormal PAPs? *(if yes, state date & results)*	

Patient name: DOB:

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PERSONAL MEDICAL HISTORY *(current and past)*	
Disease/Condition	Comments

FAMILY HISTORY	Father	Mother	Siblings	Other
Living?				
Bleeding/clotting				
Colon/bowel problems				
Cancer/type				
Diabetes				
Drug/alcohol addiction				
Depression/anxiety				
Heart disease				
High cholesterol				
High blood pressure				
Kidney disease				
Liver disease				
Suicide				
Seizures				
Stroke				
Thyroid disease				
Other:				

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SOCIAL HISTORY	
Occupation *(past/present)*:	
Retired/unemployed/disabled:	
Highest degree/years of education:	
Marital status:	
Children *(if yes, how many?)*:	
TOBACCO USE *(if applicable)*	
Smoke cigarettes?	
Packs/day:	
# of years:	
If quit, state quite date, packs/day, and # of years:	
Other forms of tobacco used:	
ALCOHOL USE *(if applicable)*	
Type of alcohol:	
# of drinks/week:	
DRUG USE *(if applicable)*	
Use or used marijuana or recreational drugs?	
Use or used needles to inject drugs?	
SEXUAL HISTORY	
Sexually involved currently?	
Gender of sexual partner(s):	
Birth control method:	
EXERCISE	
Do you exercise regularly?	
If yes, what kind of exercise/for how long/how often?	

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DIET	
How would you rate your diet? (Good/fair/poor)	
Do you drink coffee/eat/soda? (if yes, how many cups/day?)	
SAFETY	
Do you use seat belts consistently?	
Do you feel safe at home?	
Do you have an advanced directive/living will?	

OTHER PROVIDERS/SPECIALISTS		
	Name	Last visit
Cardiology		
Gastroenterology		
OB/GYN		
Neurology		
Pulmonology		
Nephrology		
Other:		