GLENDALE
PRIMARY CARE

Dr. Matthew G. Pinto

New Patient Health History Form

(Please address all questions)

Why are you here today?____

____

Current Medications:

Drug Name	Strength (mg)	How many times per day

(put additional medications on back of this page)

Medical Problems Diagnosed by a Doctor/Hospital

Year Diagnosed	Problem

Allergies	Name/Type	Reaction
Medications		
Food		
Other		

WOMEN ONLY:

Gynecologic History

Periods: ☐ Regular ☐ Irregular ☐ Heavy
Sexually Active: ☐ Yes ☐ No
Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Last Pap Smear: ____/____/______ ☐ History of Abnormal Pap

Last Mammogram: ____/____/______ ☐ History of Abnormal Mammogram

Sexually Transmitted Diseases: ☐ Herpes ☐ Warts ☐ Gonorrhea/Chlamydia

Method of Birth Control: ☐ Condoms ☐ Pill ☐ IUD ☐ None

Obstetrical History

Pregnancy	Vaginal or C/S	Complications

MEN ONLY:

Last Prostate Exam: ____/____/______ ☐ History of Abnormal Rectal Exam
☐ History of Abnormal PSA test
Sexually Active: ☐ Yes ☐ No
Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual
Sexually Transmitted Diseases: ☐ Herpes ☐ Warts ☐ Gonorrhea/Chlamydia

Surgical History

Date	Type of Surgery

(put additional surgeries on back of paper)

Overnight Hospitalizations (excluding childbirth)

Date	Hospital	Reason

Family History

please circle all medical problems

Father	Alive Deceased Age:_____	Heart Disease Cancer Diabetes High BP Alcoholism Lung Disease
Mother	Alive Deceased Age:_____	Heart Disease Cancer Diabetes High BP Alcoholism Lung Disease
Brothers	Alive Deceased Age:_____	Heart Disease Cancer Diabetes High BP Alcoholism Lung Disease
Sisters	Alive Deceased Age:_____	Heart Disease Cancer Diabetes High BP Alcoholism Lung Disease
Grandparents	Alive Deceased Age:_____	Heart Disease Cancer Diabetes High BP Alcoholism Lung Disease

Please list any other pertinent family history : ___________________________________

____

____

Social History: circle your answers

Cigarette Smoking	Alcohol	Drugs
Yes No Quit: when _________	Yes No Quit: when ________	Marijuana Yes No
Packs/day <1 1 2 3	Drinks/day: 1 2 3 4 5	Cocaine Yes No
Years you've smoked: ________	Interested in quitting: Yes No	Opiods Yes No
Interested in quitting: Yes No	Beer Wine Liquor	IV drugs Yes No

Exercise: ☐ Yes ☐ No _____ Times/week

Travel Outside the US recently: ☐ Yes ☐ No

Where:_________________________________ When: ____/____/______