

NAME: Eric Newell Date: 4/30/18

Family History: Have YOU or anyone in your family ever been treated for any of the following?

	You	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent	Other
Depression										
Anxiety										
Panic Attacks										
Post-traumatic stress										
Bipolar										
Schizophrenia										
Alcohol/Drug problems										
ADHD/ADD										
Suicide attempts										
Suicide										

☐ Check here if there is no known family history

Substance Abuse History

Regarding alcohol, when was your last drink? About 20 years ago

In the past 30 days, about how many of those days have you had at least one alcoholic drink? X

What is the maximum number of drinks you have had in one day in the past month? X

Have you ever experienced the following? DUI DWI Public Intoxication Seizures DT's

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used on this date (approximately)	Age peak use	History of abuse	Current use and frequency
Cocaine	✓					
Amphetamine or Speed	✓					
Marijuana	✓					
Pain Pills	✓					
Cigarettes, Cigars or Tobacco	✓					
Heroin	✓					
Benzodiazepines (Xanax, Valium, Ativan, Restoril, Librium)	✓					
Other:	✓					

Pharmacy Name and Number Walgreens - Atlanta Hwy

Please List all current medications below

(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc.)

Name of Medication	Dosage (Mg)	Times per Day	Dates of Use	Side Effects (if any)	Prescribing Physician

Preferred pharmacy? Walgreens - Atlanta Hwy Phone #: _____

NAME: Eric Newell Date: _____

FAMILY HISTORY: *Indicate illnesses in blood relatives. Check those that apply.*

- | | | |
|--|--|---|
| ☐ Anemia | ☒ Diabetes (type 1 or 2) | ☒ Migraines/headaches |
| ☐ Bleeding or clotting abnormally | ☐ Heart disease | ☐ Stroke |
| ☐ Breast disease | ☒ High cholesterol | ☐ Thyroid disorder (Hypo or Hyper) |
| ☐ Cancer | ☒ High blood pressure | ☐ Arthritis |
| ☒ Prostate | | ☐ Rheumatoid |
| ☐ Skin | | ☐ Osteoarthritis |
| ☐ Colon | | |
| ☐ Lung | | ☐ Connective Tissue |
| ☐ Breast | | ☐ Lupus |
| ☐ Other _____ | | Other: _____ |

SEXUAL HISTORY:

Have you ever been sexually active? ☒ Yes ☐ No

Are you currently sexually active? ☒ Yes ☐ No

Do you use protection and or contraceptives? ☐ Yes ☒ No

- | | | |
|--|-----------------------------------|---------------------------------------|
| ☐ birth control pills | ☐ IUD | ☐ Condoms |
| ☐ DepoProvera | ☐ Implants | ☐ Other: _____ |

Complete the following questions if you are sexually active:

Are you currently having sexual relations with one partner or multiple partners? ☒ One ☐ Multiple

Number of partners in last year: 1

Are/Is your sexual partner(s): ☐ men ☒ women ☐ both

Have you ever had a sexually transmitted infection (STI)(ie: HPV, Herpes, Chlamydia, Gonorrhea or other)? ☐ Yes ☒ No

List STI: _____ Treated: ☐ Yes ☐ No

GYNECOLOGICAL HISTORY:

Do you a period every month? ☐ Yes ☐ No

Number of days of flow: _____

Menstrual cramps: ☐ mild ☐ moderate ☐ severe ☐ normal

Date of last PAP smear: _____ Last PAP smear results: _____ Have you ever had an abnormal Pap smears? ☐ Yes ☐ No

If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear?

Are you presently trying to become pregnant or will be trying soon? ☐ Yes ☐ No

Have you had a mammogram? ☐ Yes ☐ No

If applicable, indicate the date and result of your last mammogram: