Robley Rex VA Medical Center
New Primary Care Patient Form

NAME: _____ **APPT DATE/TIME:** _____

Branch of service: _____ Years served: _____ Retired from service? YES NO

CIVILIAN PROVIDERS:

ALLERGIES (MEDICATION, FOOD, OTHER)

MEDICATIONS List all medications you are currently taking, including the dose and frequency

Please include herbal supplements

CONDITIONS Check ✓ conditions you currently have or have had in the past

- ☐ Heart Disease
- ☐ Thyroid
- ☐ Lung Disease
- ☐ Sleep apnea
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Tinnitus
- ☐ Cancer
- ☐ Hypertension
- ☐ Depression/Anxiety
- ☐ PTSD
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Stroke

SURGERY HISTORY

Year	Type of surgery/complications

PREGNANCY HISTORY

pregnancies ___; # living children ___
deliveries: C-section ___; Vaginal ___

OTHER HOSPITALIZATION/SERIOUS INJURY

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FAMILY HISTORY

Fill in information about your family below

Relation:	Age, if living or at death	Cause of death
Father		
Mother		
Siblings		

Check ✓ if a blood relative has had any of the following:

Disease	Relationship to you:
☐ Heart Disease	
☐ Lung Disease	
☐ Cancer	
☐ Diabetes	
☐ Hypertension	
☐ Other: _____	

SOCIAL HISTORY

Marital Status:

HEALTH HABITS Check ✓ appropriate boxes and describe

Tobacco	☐ None	___ cigarettes per day OR How long does can of tobacco last ___ Quit using around _____
Alcohol	☐ None	___ # of drinks per ____
Drugs	☐ None	Describe:
Diet		
Exercise		

HEALTH MAINTENANCE List most recent date for each of the following:

MEN ONLY	BOTH MEN AND WOMEN		WOMEN ONLY
Digital rectal exam ____	Flu vaccine _____	Pneumovax ____	Menstrual period ___
PSA test ____	Colonoscopy _____	Prevnar _____	Mammogram _____
	Tetanus booster ____	TDAP _____	Pap smear _____
	Shingles vaccine ___		

ADDITIONAL INFORMATION:

Did you served in Iraq or Afghanistan since 9/2001? Yes/No

What else do you think your doctor should know about your health?