First Appointment

You can complete the highlighted fields on this form online and then print the form for easy reference. Only text that is visible on the form is printed; scrolled text will not print. Any text you enter into these fields will be cleared when you close the form; you cannot save it.

Print this form and fill in the information if you are seeing this health professional for the first time. Although you may have to complete a similar form when you arrive at the office, completing this form will help you organize your thoughts and provide more complete information.

Complete Section 2 at the end of your appointment if you have a health problem that needs treatment.

Section 1: Current health and health history
Reason for appointment
Why did I make this appointment?
Am I having any symptoms? Describe them. If pain is one of my symptoms, include where it is, how it feels, and how severe it is.
Has there been a recent change in my normal routine (for example, sleeping, eating, recent death of a loved one, divorce)?

Questions for women	
Am I pregnant? ◯ Yes ◯ No	When was my last menstrual period?
At what age did my menstrual cycles begin?	My cycles are: ◯ Regular ◯ Irregular
When was my last mammogram?	
If the results were abnormal, explain:	
When was my last Pap smear?	
If the results were abnormal, explain:	
When was I last screened for colon cancer (if I am older than 50)?	
If the results were abnormal, explain:	

Questions for men
When was my last prostate examination (if I am older than 50 and younger than 75)?
If the results were abnormal, explain:
When was I last screened for colon cancer (if I am older than 50)?
If the results were abnormal, explain:

Immunization history			
Immunization	**Date last received**	**Immunization**	**Date last received**
Influenza		Hepatitis B	
Pneumococcal		Shingles	
Tetanus (Td and Tdap)		Other	

Health history	
Fill in your current health problems, such as poor eyesight or diabetes, and the name of the health professional you see for each problem.	
Health problem	**Health professional**

Hospitalizations			
Fill in the information for each time you have been in the hospital. Include any surgeries you have had on an outpatient basis.			
When was I there? (date or year)	**Why was I in the hospital?**	**Who was my doctor?**	**What hospital was I in?**

Allergies	
Fill in the following information if you have allergies to medicines or other substances.	
Medicine or other substance	**My reaction**

Family history				
List family members (parents, brothers, sisters, grandparents) who have or had the following major conditions.				
Health condition	**Relative (parent, brother, sister, grandparent)**	**Age, if living**	**Age at death**	**Comments**
Heart problems				
Kidney disease				
Lung disease				
Depression or other major mental health condition				
Diabetes				
Breast cancer				
Colon cancer				
Other cancer or inherited disease				

Tobacco and alcohol use		
☐ I have never used tobacco products (cigarettes, pipes, cigars, or chewing tobacco).		
Fill in the following information if you currently use or have ever used tobacco products.		
Product (cigarettes, pipe, cigars, or chewing tobacco)	**How much am I using now, or how much did I use before I quit?** (for example, 1 pack of cigarettes a day or 1 cigar about once a week)	**How long has it been since I quit?**
How many days a week do I drink alcohol?		
How many alcohol drinks do I typically have when I drink?		

Physical exercise		
What type of exercise do I do? (for example, walking, jogging, stretching)	**How frequently do I exercise?** (for example, 3 times a week)	**How long do I exercise each time?** (for example, 10 minutes, 30 minutes)

Personal preferences
Do I have any cultural, religious, or personal beliefs that may affect my treatment options? Describe them briefly:
What other concerns do I have?

Stop here. By the end of your appointment, make sure you have answers to the questions in Section 2 if you need treatment for a health problem as the result of this visit.

Section 2: Treatment for this health problem and next steps		
What is the diagnosis?		
What does it mean in plain English?		
What might happen next?		
Do I need a medicine? ◯ Yes ◯ No If yes, fill in the following information.		
Name of medicine	**How much and how often to take it**	**What to watch for**
Do I need surgery or another treatment? ◯ Yes ◯ No If yes, fill in the following information.		
Name of treatment	**Who will do it**	**Where it will be done and what to do to prepare for it**

What are the risks and benefits of medicine, surgery, or other treatment? Fill in the following information about the treatment your health professional recommends for this condition.
What are the chances that the treatment will work?
What are the risks associated with the treatment?
What might happen if I delay or avoid treatment?
How soon will I see results of the treatment?
What other treatment options are available?
Do I need a medical test or X-ray? ◯ Yes ◯ No If yes, fill in the following information.
What is the name of the test?
Will the test results change the treatment? If yes, explain:
How do I get the test results?
What home treatment can I do? Ask the following questions about what you can do to help treat your condition.
What do I need to change? How?

Eating:	
Sleeping:	
Exercise:	
Other:	

What home treatment do I need to add? (for example, using a humidifier)
Do I have concerns about being able to carry out my part of the treatment? ◯ Yes ◯ No If yes, discuss them with your health professional now.
Where can I get more information about this problem or the treatment?
How soon do I need to make a decision about getting a test or starting treatment?
What signs and symptoms should I watch for?
When should I call to report signs and symptoms?
Is there a chance that someone else in my family might get the same condition?
When should I contact my health professional? Fill in the appropriate box below with the date and time, if needed.

Check here if no contact is needed.	**Call for test results or to report how I am doing:**		**Return for an appointment:**	
☐	Date:	Time:	Date:	Time:

Reminder

Bring to your appointment all your medicines or a list of all the medicines you are taking.