CHRISTOPHER NEWPORT UNIVERSITY
HEALTH & WELLNESS SERVICES

Offered in partnership with Riverside Health System

NEW PATIENT HEALTH INFORMATION FORM

Date: _____/_____/_____

DOB: _____/_____/_____ SSN:_______/_______/_______ CNU ID#: ______________________

Name:____ Age: _____________
LAST FIRST MIDDLE

Home Address:

____
STREET CITY STATE ZIP

Contact Phone#: (_____) ______-________ Local Residence Hall: ________________________

E-Mail Address: _________________________________ Race: ____________ Sex: ___________

In Case of Emergency Contact: _________________________________ Phone ____________________
Name/Relationship

Medications: Please list all Prescriptions, Over the counter medications, Vitamins, Herbals, Performance Enhancers, etc. that you are currently taking.

Drug Name/Strength	**Dose**
1. __________________________________	___________________
2. __________________________________	___________________
3. __________________________________	___________________
4. __________________________________	___________________

Allergies: List any allergies, including Food Allergies: ____

____

Medical History: Circle all that apply.

High Blood Pressure	Diabetes	Cancer	Heart Disease
Shortness of Breath	Swollen Ankles	Palpitations	Lightheadedness
Stroke	High Cholesterol	Chest Discomfort	Fever/Chills, sweats
Pneumonia	Persistent Cough	Tuberculosis	Asthma
Hay Fever	Indigestion/Heartburn	Abdominal Discomfort	Change in Appetite
Constipation/Diarrhea	Blood in Stool	Chickenpox	Ulcers
Hemorrhoids	Gallbladder Disease	Hepatitas/Liver Disease	Thyroid Disease
Seizures	Headaches	Incontinence	Kidney Disease
Kidney Stones	Difficulty Urinating	Urine Infections	Mono
Arthritis	Blood Disorder	Sickle Cell	Blood Clots
Anemia	Anxiety	Depression	Skin Diseases
Hearing Difficulty	Gout	Low Back Problems	Glasses or Contacts
Glaucoma /Cataracts	Unexplained Weight Gain		Unexplained Weight Loss

Any problems not listed above: ____

Significant Medical Family History to be noted:______________________________________

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____

Please list any surgeries or hospitalizations you have had, please include the year: ______________

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____

Date of Last Menstrual Cycle (females): _________________

Prevention History:

Do you smoke or use tobacco products? Y / N If "yes" Packs per day _____________ Quit? _________________

Do you drink alcoholic beverages? Y / N If "yes" how much/many per day/week? ______________________

Do you exercise? Y / N If "yes" how many times per week? _________________________

Have you ever used or are you using drugs (Marijuana, Cocaine, Crack, Speed, Etc)? Y / N
If "Yes" please list: ____

Is there anything you wish to discuss with the provider privately? ____

Have you ever been verbally, physically or sexually assaulted? Y / N