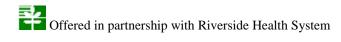
## CHRISTOPHER NEWPORT UNIVERSITY HEALTH & WELLNESS SERVICES



## NEW PATIENT HEALTH INFORMATION FORM

Date:/				
DOB:/	SSN:/	/ CNU IDa	#:	
Name:			Age:	
LAST	FIRST	MIDDLE	1.50	
Home Address:				
STRE	ET	CITY	STATE ZIP	
Contact Phone#: (		Local Residence Hall:		
E-Mail Address:		Race:	Sex:	
In Case of Emergency C	ontact:	Pho	ne	
<i>5</i> ,	Name/Relations	ship		
Drug Name/Strength  1  2  3  4  Allergies: List any aller		Dose		
Medical History: Circle High Blood Pressure		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 Ga	ın	Unexplained Weight Loss	

Any problems not listed above:	
Significant Medical Family History to be n	noted:
	s you have had, please include the year:
Date of Last Menstrual Cycle (females): _	
Prevention History:	
Do you smoke or use tobacco products? Y / N	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 (Ma If "Yes" please list:	rijuana, Cocaine, Crack, Speed, Etc)? Y / N
Is there anything you wish to discuss with the p	rovider privately?
Have you ever been verbally, physically or sexu	ually assaulted? Y / N