GUARDIAN PRIMARY CARE

EMPOWERED IN CARE, EXCELLENCE IN HEALTH

Updated: 9.30.2025

Guardian Health - New Patient Health History Form

This form may also be completed electronically on the PatientAlly Portal at: https://www.patientally.com/login

PLEASE BE SURE TO PROVIDE US WITH THE PATIENT'S AND/OR LEGAL GUARDIAN'S GOVERNMENT ID (e.g., DRIVER'S LICENSE) & INSURANCE CARD TO YOUR VISIT AS APPLICABLE

****Financial Note: If the patient is insured, please note that for us to provide a proper estimate of the cost to the patient with respect to their insurance benefits, we ask that insurance information be provided at a minimum of 24 business hours prior to the patient's visit. If the patient self-pay, the clinic's self-pay rates are available upon request.***

Patient Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Phone Number:** _____
- **Email:** _____
- **Address:** _____
- **Preferred Communication:** ☐ Call ☐ Text ☐ Email

- **Preferred Pharmacy:** _____ (Location: _____)

Emergency Contact

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

Insurance Information (*SKIP IF YOU PROVIDED YOUR INSURANCE CARD)

- **Primary Insurance Provider:** _____
- **Insurance Address:** _____
- **Provider Contact #:** _____
- **Subscriber Name:** _____
- **ID #:** _____
- **Group #:** _____
- **Secondary Insurance (if applicable):** _____

Medical History

- **Allergies (medications, food, environment):**

  _____

  _____

- **Current Medications (Name, Dose, Frequency):**

  _____

_____

_____

_____

- **Past Medical Conditions (Check all that apply):**

  ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Asthma ☐ COPD ☐ Cancer ☐ Thyroid Disorder

  ☐ Anxiety ☐ Depression ☐ Kidney Disease ☐ GI Issues ☐ Other (Please Specify):

  _____

  _____

  _____

  _____

- **Past Surgeries/Hospitalizations (List dates & reasons):**

  _____

  _____

  _____

  _____

- **Specialists You See (e.g., cardiologist, endocrinologist):**

  _____

  _____

_____

_____

Family Medical History (Check all that apply):

☐ Heart Disease ☐ Diabetes ☐ Stroke ☐ Cancer ☐ High Blood Pressure ☐ Mental Illness

☐ Other (if selected, please explain below)

_____

_____

Has anyone in your family been diagnosed with cancer or suffer an early death?

☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

Lifestyle & Social History

- **Occupation: _____**
- **Tobacco Use:** ☐ Never ☐ Former Smoker ☐ Current Smoker - Packs/day: _____
    - If you smoke, how long have you smoked? _____
- **Do you Drink Caffeine?:** ☐ Yes ☐ No

    - If yes, what do you drink, how much, & how often? _____
- **Alcohol Use:** ☐ None ☐ Social ☐ Regular (Drinks/week: _____)
- **Drug Use:** ☐ None ☐ Marijuana ☐ Prescription Misuse ☐ Other (Please Specify):

  _____
- **Exercise:** ☐ None ☐ 1-2x/week ☐ 3+ times/week - Type: _____
- **Diet:** ☐ Well-balanced ☐ High-fat ☐ Vegetarian ☐ Other: _____
- **Sexually Active:** ☐ Yes ☐ No | **Birth Control Method:** _____
- **History of STDs:** ☐ Yes ☐ No
- Occupation: _____
- **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Other: _____
- **Have you ever been pregnant?:** ☐ Yes ☐ No
    - If yes:
        - How many pregnancies have you had?: _____
        - How many children do you have today?: _____
        - **Any History of Birthing Complications?:** ☐ Yes ☐ No

If yes, please Explain:

_____

_____

- **Do You Have any Disabilities?:** ☐ Yes ☐ No
    - If so, please explain: _____
- **What is Your Occupation?: _____**
- **When is the last time you went to the Dentist?: _____**
- **When is the last time you went to the Eye Doctor?: _____**

Mental Health History

- **History of Depression, Anxiety, PTSD, or Other Conditions?** ☐ Yes ☐ No
- **Current or Past Therapy?** ☐ Yes ☐ No
- **Medications for Mental Health?** ☐ Yes ☐ No

Personal Safety Screening (Standard for All Patients):

- Has anyone ever harmed or threatened you? ☐ Yes ☐ No
- Do you feel safe at home? ☐ Yes ☐ No
- Have you ever been forced into sexual activity? ☐ Yes ☐ No

Advance Directives (For Adult & Elderly Patients):

- Do you have a **Do Not Resuscitate (DNR) Order?** ☐ Yes ☐ No
- Do you have a **Living Will or Power of Attorney for Healthcare?** ☐ Yes ☐ No

Preventive Care & Vaccinations

- **Last Physical Exam: _____**
- **Last Blood Work: _____**
- **Vaccinations (Check all received):**

  ☐ Flu ☐ COVID-19 ☐ Tdap ☐ Hepatitis B ☐ HPV ☐ Shingles ☐ Pneumonia

  ☐ Childhood Vaccines

- **Women Only:** Last Pap Smear: _____ | Last Mammogram: _____
- **Men Only:** Last Prostate Exam: _____

Pediatric History (For Patients <18 years old)

- **Gestational Age at Birth: _____** weeks

- **Born Prematurely?** ☐ Yes ☐ No (If yes, how many weeks early? _____)
- **Delivery Type:** ☐ Vaginal ☐ C-section
- **Complications at Birth?** ☐ Yes ☐ No (If yes, explain:

  _____)
- **NICU Admission?** ☐ Yes ☐ No
- **Prolonged Oxygen Use?** ☐ Yes ☐ No
- **Birth Weight:** _____ lbs _____ oz
- **Passed Newborn Hearing Screen?** ☐ Yes ☐ No
- **Abnormal PKU Test Results?** ☐ Yes ☐ No (If yes, explain: _____)

Pediatric Safety Screening

- **Car Seat Used at All Times?** ☐ Yes ☐ No
- **Helmet Used for Sports?** ☐ Yes ☐ No
- **Smoke/Carbon Monoxide Detectors in Home?** ☐ Yes ☐ No
- **Firearms in Home?** ☐ Yes ☐ No (If yes, are they locked and secured? ☐ Yes ☐ No)
- **Home Water Heater Set at 120°F or less?** ☐ Yes ☐ No

Pediatric Feeding & Nutrition

- **Breastfed?** ☐ Yes ☐ No (If yes, how many minutes per feeding? _____, How many times per day? _____)
- **Formula-fed?** ☐ Yes ☐ No (If yes, brand & ounces per feeding: _____)
- **Started Solid Foods?** ☐ Yes ☐ No
- **Any feeding problems?** ☐ Yes ☐ No (If yes, explain: _____)

Additional Health Notes

If you have any additional information you would like to share with your Provider, please list it here:

_____

_____

_____

_____

Consent & Acknowledgment

By signing below, I confirm that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____