SMART COMPREHENSIVE HEALTH
Jennifer C. Balde, M.D., F.A.C.P
811 S. Auburn St.
Phone: 509-866-4145 Fax: 509-866-4146

NEW PATIENT HISTORY:

GENERAL HISTORY:

Name: _____ Age:_____ DOB____/____/_____
Main reason for your visit: _____
Preferred Pharmacy: 1: _____ 2:_____

SOCIAL HISTORY:

Marital status: _____ Who lives with you: _____
How many people live with you:_____
Where do you live: _house _apartment _nursing home _assisted living
Sex at birth:_____ Gender Identity:_____
Preferred pronoun:_____
Employment Status:_____ Current or Prior occupation:_____
Highest level of education:_____
Did you ever smoke: _____
Chew Tobacco:__Yes __No Electronic cigarette:__Yes __No Vaping:__Yes __No
Marijuana use: __Yes __No If yes, what type and how often? _____
Alcohol intake: __Yes __No If yes, what type and how often? _____
Recreational drugs:__Yes __No If yes, what type and how often? _____
Exercise time/type: :__Yes __No If yes, what type and how often? _____
Do you have sex with: __Men __Women __Both
Age of children (if any):_____
Are you concerned that you may have been exposed to HIV:_____

	Current use	Past use	How often/week	How often/day
Smoking				
Caffeine				
Alcohol				
Drug use				

ALLERGIES: _____
Drug: _____ Reaction:_____
Drug: _____ Reaction:_____
Drug:_____ Reaction:_____
Drug:_____ Reaction:_____
Drug:_____ Reaction:_____

PAST MEDICAL HISTORY:

CONDITION		What year?	CONDITION		What Year?
High blood pressure	_Yes _ No		Bleeding disorder	_Yes _ No	
High cholesterol	_Yes _ No		Epilepsy/seizure	_Yes _ No	
Diabetes	_Yes _ No		Glaucoma	_Yes _ No	
Arthritis	_Yes _ No		Gout	_Yes _ No	
Back pains	_Yes _ No		Hypothyroidism	_Yes _ No	
Chronic pain	_Yes _ No		AIDS/HIV	_Yes _ No	
Chronic fatigue	_Yes _ No		Anemia	_Yes _ No	
Fibromyalgia	_Yes _ No		Hernia	_Yes _ No	
COPD	_Yes _ No		Migraines	_Yes _ No	
Asthma	_Yes _ No		Multiple sclerosis	_Yes _ No	
COVID 19	_Yes _ No		Allergic rhinitis	_Yes _ No	
Gastritis/Ulcer	_Yes _ No		Tuberculosis	_Yes _ No	
Irritable bowel	_Yes _ No		Leg swelling	_Yes _ No	
Heart failure	_Yes _ No		Kidney Stones	_Yes _ No	
Heart attack	_Yes _ No		Hepatitis	_Yes _ No	
Stroke	_Yes _ No		Enlarged prostate	_Yes _ No	
Depression:	_Yes _ No		Sinusitis	_Yes _ No	
Other:	_Yes _ No		Other:	_Yes _ No	

CANCER:_____ Year of diagnosis: _____ Stage:_____
Treatment:_____
_____
_____

SURGERIES: _____
_____
_____
_____

Have you Been Diagnosed with:

__Depression __Anxiety __Panic __PTSD __Bipolar disorder __Schizophrenia
Other:_____

Have you had any suicide Attempts:__Yes __No When?_____

Have you been hospitalized because of a psychiatric condition? __Yes __No

Do you have any life stressors? __Yes __No If yes, please describe:_____

MEDICATIONS

MEDICATION	DOSE	TIMES/DAY	REASON
Example: Tylenol	500mg tablet	2 times a day	Back pain

Who are the doctors you have seen in the last 5 years?
_____
_____
_____

May we request records from them? __Yes__ No (If yes, will need a release form signed before initial appointment.)

HEALTH MAINTENANCE:

TEST		Year Done	RESULT
Mammogram (female)	__Yes __ No		__Normal __Abnormal
PAP Smear (female)	__Yes __ No		__Normal __Abnormal
PSA (male)	__Yes __ No		__Normal __Abnormal
Abdominal aortic aneurysm (males)	__Yes __ No		__Normal __Abnormal
Lung Cancer Screening (CT Scan)	__Yes __ No		__Normal __Abnormal
Chest X ray	__Yes __ No		__Normal __Abnormal
Colonoscopy/colon cancer screening	__Yes __ No		__Normal __Abnormal
EGD	__Yes __ No		__Normal __Abnormal
Electrocardiogram	__Yes __ No		__Normal __Abnormal
Echocardiogram	__Yes __ No		__Normal __Abnormal
Stress test	__Yes __ No		__Normal __Abnormal
Eye Exam	__Yes __ No		__Normal __Abnormal
HIV	__Yes __ No		__Normal __Abnormal

VACCINATION HISTORY:

COVID 19 VACCINE		If yes, date of vaccination:	Reactions:
Flu vaccine	__Yes __ No		
Pneumonia 23	__Yes __ No		
Pneumonia 13	__Yes __ No		
Hepatitis A (2 shots)	__Yes __ No		
Hepatitis B (3 shots)	__Yes __ No		
Gardasil vaccine (HPV)	__Yes __ No		
Tetanus (Td or Tdap)	__Yes __ No		
Varicella	__Yes __ No		
Zoster	__Yes __ No		
MMR	__Yes __ No		
Meningococcal vaccine	__Yes __ No		

FAMILY HISTORY		Age (or Age at death)	Cause of Death
Father	__Living __Deceased		
Mother	__Living __Deceased		
Sibling	__Living __Deceased		
Sibling	__Living __Deceased		
Children	__Living __Deceased		
Children	__Living __Deceased		
Maternal Grandmother	__Living __Deceased		
Maternal Grandfather	__Living __Deceased		
Paternal Grandmother	__Living __Deceased		
Paternal Grandfather	__Living __Deceased		

Put a check mark to indicate which of your relatives have had the following conditions.

Family History	Father	Mother	Siblings	Children	Other
Heart Disease					
Stroke					
Seizure/Epilepsy					
Diabetes mellitus					
Early Death/Sudden Death					
Addition (Alcohol/drugs)					
Kidney Disease					
Depression					
Anxiety/mental illness					
Colon Polyps					
Colon Cancer					
Breast Cancer					
Prostate Cancer					
Other (Specify					

Signature of patient/representative:_____ Date: _____/_____/_____