Dr. B.S Fick
Wellness Clinic

New Patient Medical History Form

Name: _____ Date: _____ :

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

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FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MGM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MGF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PGM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PGF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*		
Sexual partner(s) is/are/have been: ❑ Male ❑ Female			
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy			
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*		
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____		
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?		
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N	
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N	
Working smoke detector in home? Y N	If you have guns at home, are they locked up? Y N		
Is violence at home a concern for you? Y N	Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N		

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

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Main Complaint MARK [X] ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
Activity change	Chest pain	Color change
Appetite change	Leg swelling	Pallor
Chills	Palpitations	Rash
Diaphoresis	**Gastrointestinal**	Wound
Fatigue	Abdominal distention	**ALLERGY/IMMUNO**
Fever	Abdominal pain	Environmental allergies
Unexpected weight change	Anal bleeding	Food allergies
HEAD, EAR, NOSE & THROAT	Blood in stool	Immunocompromised
Congestion	Constipation	**NEUROLOGICAL**
Dental problem	Diarrhea	Dizziness
Drooling	Nausea	Facial asymmetry
Ear discharge	Rectal pain	Headaches
Ear pain	Vomiting	Light-headedness
Facial swelling	**ENDOCRINE**	Numbness
Hearing loss	Cold intolerance	Seizures
Mouth sores	Heat intolerance	Speech difficulty
Nosebleeds	Polydipsia	Syncope
Postnasal drip	Polyphagia	Tremors
Rhinorrhea	Polyuria	Weakness
Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
Sneezing	Difficulty urinating	Adenopathy
Sore throat	Dysuria	Bruises/bleeds easily
Tinnitus	Enuresis	**PSYCHIATRIC**
Trouble swallowing	Flank pain	Agitation
Voice change	Frequency	Behavior problem
EYES	Genital sore	Confusion
Eye discharge	Hematuria	Decreased concentration
Eye itching	Penile discharge	Dysphoric mood
Eye pain	Penile pain	Hallucinations
Eye redness	Penile swelling	Hyperactive
Photophobia	Scrotal swelling	Nervous/anxious
Visual disturbance	Testicular pain	Self-injury
RESPIRATORY	Urgency	Sleep disturbance
Apnea	Urine decreased	Suicidal ideas
Chest tightness	**MUSCULAR**	
Choking	Arthralgias	
Cough	Back pain	
Shortness of breath	Gait problems	
Stridor	Joint swelling	
Wheezing	Myalgias	
	Neck pain	
	Neck stiffness	

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