

New Patient Medical History Form

Name:	Date:	:	:
Birth Date:	Age:		

ALLERGIES D NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

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

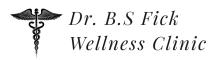
If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	CHOLESTEROL Date:		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 (<i>Pneumonia</i>):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (Shingles):	



PERSONAL MEDICAL HISTORY

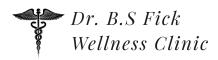
DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type:)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type:)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease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



FAMILY MEDICAL HISTORY

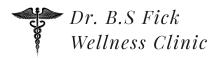
✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	(type: Cancer)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:	Other:	Other:
Mother																		
Father																		
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)							
<i>Current:</i> Packs/day	/	# of Years	Past: Quit [Date: I	/day	# of Years		
Other Tobacco (che	ck one):	🗅 Pipe 🗅 Cigar 🗆	🕽 Snuff 🕒 Che	W				
ALCOHOL/DRUG USE Do you drink alcohol? Y			hol? Y N	Beer Uvine 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 take	one else's drugs? Y	N						



OTHER HEALTH ISSUES continued...

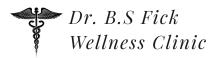
SEXUAL ACTIVITY Sexually involved currently? Y N (If no sexual history, please continue to Exercise)								
Sexual part	Sexual partner(s) is/are/have been: 🗅 Male 🗅 Female							
Birth control method: 🗅 None 🗅 Condom 🗅 Pill/Ring/Patch/Inj/IUD 🗅 Vasectomy								
EXERCISE Do you exercise regularly? Y N (If you answered no, please move to Sleep)								
What kind	of exercise?		Durat	<i>ion:</i> How long (min.): How often:				
SLEEP	How many	/ hours, on average, do you sleep at nig	ght <i>(or du</i>	ring 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 ι	use a bike helmet? Y N	u 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 co	ncern 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?



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	