**NEW PATIENT MEDICAL HISTORY FORM**

Full Name: Date:

Date of Birth: Age:

Reason for visit:

**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*

**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: |  |  |  |

**ALLERGIES NO KNOWN ALLERGIES**

|  |  |
| --- | --- |
| **ALLERGY** | **ALLERGIC REACTION** |
|  |  |
|  |  |
|  |  |

**SURGERIES**

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

**HOSPITALIZATIONS**

|  |  |  |
| --- | --- | --- |
| **REASON** | **DATE** | **LOCATION** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**VACCINATION HISTORY**

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

**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? |

**FAMILY MEDICAL HISTORY NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CHECK ALL THAT APPLY** | ALCOHOL/DRUG ABUSE | ASHTMA | 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL GRANDMOTHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL GRANDFATHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL GRANDMOTHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL GRANDFATHER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**SOCIAL HISTORY**

|  |  |
| --- | --- |
| Occupation *(or prior occupation):* |  Retired Unemployed Leave 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  |
| 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 all that apply)*: 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 |  |
| **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 many days a week?:\_\_\_\_\_\_\_\_\_ |
| **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 |

**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: |

**HEALTH MAINTENANCE SCREENING TEST HISTORY**

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

**OTHER PROVIDERS/SPECIALISTS**

|  |  |  |
| --- | --- | --- |
| **SPECIALIST** | **NAME** | **LAST VISIT** |
| Cardiology |  |  |
| Gastroenterologist (GI) |  |  |
| OB/GYN |  |  |
| Neurology |  |  |
| Pulmonary |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

Have you completed an Advance Directive for Health Care (ADHC), Living Will? Y N

***If yes, please feel out the following:***

**My Durable Power of Attorney for Health Care**

\_\_\_\_\_\_ I, , appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made in the parts of the form that follow.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone: Work Telephone:

Address:

If the person above cannot or will not make decisions for me, I appoint this person:

Name:

Home Telephone: Work Telephone:

Address:

Patient’s Name Date:

Patient’s Signature Date:

**REVIEW OF SYSTEMS- CHECK ALL THAT APPLY**

|  |  |  |
| --- | --- | --- |
| **CONSTITUTION** | **CARDIOVASCULAR** | **SKIN** |
|  | Activity change |  | Chest pain |  | Color change |
|  | Appetite change |  | Leg swelling |  | Pallor |
|  | Chills |  | Palpitations |  | Rash |
|  | Excessive sweating | **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 drooping |
|  | 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 |  | Excessive thirst |  | Fainting |
|  | Postnasal drip |  | Excessive appetite |  | Tremors |
|  | Runny nose |  | Frequent urination |  | Weakness |
|  | Sinus pressure | **GENITOURINARY** | **HEMATOLOGIC** |
|  | Sneezing |  | Difficulty urinating |  | Enlarged lymph nodes |
|  | Sore throat |  | Dysuria |  | Bruises/bleeds easily |
|  | Ringing ears |  | Bedwetting | **PSYCHIATRIC** |
|  | Trouble swallowing |  | Flank pain |  | Agitation |
|  | Voice change |  | Genital sore |  | Behavior problem |
| **EYES** |  | Bloody urine |  | Confusion |
|  | Eye discharge |  | Penile discharge |  | Decreased concentration |
|  | Eye itching |  | Penile pain |  | Depression |
|  | Eye pain |  | Penile swelling |  | Hallucinations |
|  | Eye redness |  | Scrotal swelling |  | Hyperactive |
|  | Sensitivity to light |  | Testicular pain |  | Nervous/anxious |
|  | Floaters |  | Urinary urgency |  | Self-harm |
| **RESPIRATORY** |  | Urine decreased |  | Difficulty sleeping |
|  | Apnea | **MUSCULAR** |  | Suicidal ideas |
|  | Chest tightness |  | Joint pain |  |  |
|  | Choking |  | Back pain |  |  |
|  | Cough |  | Gait problems |  |  |
|  | Shortness of breath |  | Joint swelling |  |  |
|  | Noisy breathing |  | Muscle pain |  |  |
|  | Wheezing |  | Neck pain |  |  |
|  |  |  | Neck stiffness |  |  |