NEW PATIENT MEDICAL HISTORY FORM

Full 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?

Patient Name: ____ DOB: ____________________

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REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

CONSTITUTION
- Activity change
- Appetite change
- Chills
- Diaphoresis
- Fatigue
- Fever
- Unexpected weight change

HEAD, EAR, NOSE & THROAT
- Congestion
- Dental problem
- Drooling
- Ear discharge
- Ear pain
- Facial swelling
- Hearing loss
- Mouth sores
- Nosebleeds
- Postnasal drip
- Rhinorrhea
- Sinus pressure
- Sneezing
- Sore throat
- Tinnitus
- Trouble swallowing
- Voice change

EYES
- Eye discharge
- Eye itching
- Eye pain
- Eye redness
- Photophobia
- Visual disturbance

RESPIRATORY
- Apnea
- Chest tightness
- Choking
- Cough
- Shortness of breath
- Stridor
- Wheezing

CARDIOVASCULAR
- Chest pain
- Leg swelling
- Palpitations

Gastrointestinal
- Abdominal distention
- Abdominal pain
- Anal bleeding
- Blood in stool
- Constipation
- Diarrhea
- Nausea
- Rectal pain
- Vomiting

ENDOCRINE
- Cold intolerance
- Heat intolerance
- Polydipsia
- Polyphagia
- Polyuria

Genitourinary
- Difficulty urinating
- Dysuria
- Enuresis
- Flank pain
- Frequency
- Genital sore
- Hematuria
- Penile discharge
- Penile pain
- Penile swelling
- Scrotal swelling
- Testicular pain
- Urgency
- Urine decreased

MUSCULAR
- Arthralgias
- Back pain
- Gait problems
- Joint swelling
- Myalgias
- Neck pain
- Neck stiffness

SKIN
- Color change
- Pallor
- Rash
- Wound

ALLERGY/IMMUNO
- Environmental allergies
- Food allergies
- Immunocompromised

NEUROLOGICAL
- Dizziness
- Facial asymmetry
- Headaches
- Light-headedness
- Numbness
- Seizures
- Speech difficulty
- Syncope
- Tremors
- Weakness

HEMATOLOGIC
- Adenopathy
- Bruises/bleeds easily

PSYCHIATRIC
- Agitation
- Behavior problem
- Confusion
- Decreased concentration
- Dysphoric mood
- Hallucinations
- Hyperactive
- Nervous/anxious
- Self-injury
- Sleep disturbance
- Suicidal ideas

Patient Name: ______________________________ DOB: ______________