**NEW PATIENT**

**MEDICAL HISTORY FORM**

Full Name:

Date:

Birth Date:

Age:

**ALLERGIES**  **NO ALLERGIES**

**MEDICATIONS**

*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**

**VACCINATION HISTORY**

Last Tetanus Booster or TdaP:

Last Pnuemovax *(Pneumonia)*:

Last Flu Vaccine:

Last Prevnar:

Last Zoster Vaccine *(Shingles)*:

**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

**MEDICATIONS**

*(Please list ALL)*

**DOSE**

*(Mg., pill, etc.)*

**TIMES PER DAY**

**ALLERGY**

**ALLERGIC REACTION**

**PERSONAL MEDICAL HISTORY**

**SURGERIES**

**WOMEN’S HEALTH HISTORY**

Patient Name:

DOB:

Date of Last Menstrual Cycle:

Age of First Menstruation: Age of Menopause:

Total Number of Pregnancies:

Number of Live Births:

Pregnancy Complications:

**TYPE** *(specify left/right)*

**DATE**

**LOCATION/FACILITY**

**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:

**FAMILY MEDICAL HISTORY**

o **NO SIGNIFICANT FAMILY hISTORY IS KNOwN**

**SOCIAL HISTORY**

**OTHER HEALTH ISSUES**

Patient Name:

DOB:

*(type:\_\_\_\_\_\_\_\_\_\_\_\_\_)*

**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)*: o Pipe o Cigar o Snuff o Chew

**ALCOhOL/DRUG USE**

Do you drink alcohol? Y N

o Beer o Wine o 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

Occupation *(or prior occupation)*:

o Retired o Unemployed o LOA o Disabled

Employer:

Years of Education or Highest Degree:

If employed, do you work the night shift? Y N N/A

Marital Status *(check one)*: o Single o Partner o Married o Divorced o Widowed o Other:

Do you have children? Y N

If yes, how many?

4 **ChECK ALL ThAT APPLY**

Alcohol/Drug Abuse

Asthma

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:

**OTHER HEALTH ISSUES continued...**

**OTHER PROVIDERS/SPECIALISTS**

**ADDITIONAL INFORMATION**

Patient Name:

DOB:

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?

**SPECIALIST**

**NAME**

**LAST vISIT**

Cardiology

Gastroenterologist (GI)

OB/GYN

Neurology

Pulmonary

Other:

Other:

**SExUAL ACTIvITY**

Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*

Sexual partner(s) is/are/have been: o Male o Female

Birth control method: o None o Condom o Pill/Ring/Patch/Inj/IUD o 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? o Good o Fair o 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

**REVIEW OF SYSTEMS**

**🗸 CHECK ALL THAT APPLY**

Patient Name:

DOB:

**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