# New Patient

**Medical History Form**

**Name**: **Date of Birth: Today’s Date**: \_\_\_\_\_\_\_\_\_\_

## Reason you are here:

**Personal Medical History:** Have you ever had any of the following conditions? (Check if yes)

|  |  |  |
| --- | --- | --- |
|  Anemia   Arthritis   Asthma   Cancer   Chronic Obstructive Pulmonary   Disease   Clotting Disorder   Congestive Heart Failure |  Crohn’s Disease   Depression   Diabetes   Emphysema   Endocrine Problems   GERD   Glaucoma   Hepatitis |  HIV/ AIDS   Hypertension   Kidney Disease   Myocardial Infarction   Peptic Ulcer Disease   Seizures   Stroke   Ulcerative Colitis |

**Personal Surgical History:** Have you ever had any of the following surgeries? (Check if yes)

|  |  |  |
| --- | --- | --- |
|  Adrenal Gland Surgery   Appendectomy   Bariatric Surgery   Bladder Surgery   Breast Surgery   Cesarean Section   Cholecystectomy |  Colon Surgery   Coronary Artery Bypass Graft   Esophagus Surgery   Gastric Bypass Surgery   Hemorrhoid Surgery   Hernia Repair   Hysterectomy |  Kidney Surgery   Neck Surgery   Prostate Surgery   Small Intestine Surgery   Spine Surgery   Stomach Surgery   Thyroid Surgery |

List names and dates of surgeries:

## Medications:

**Allergies:**

**Family History:** Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

|  |  |  |
| --- | --- | --- |
|  Cancer/Polyps Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma  Other |  Anemia   Diabetes   Blood Clots   Heart Disease   Stroke |  High Blood Pressure   Anesthesia Reaction   Bleeding Problems   Hepatitis   Other |

**Social History:**

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol use - |  Never |  Occasionally |  Daily Type |
| Tobacco use - |  Never |  Previously, but quit |  Packs Per Day for years |
| Drugs use - |  Never |  Occasionally |  Daily Type |

What is your occupation?

Marital Status:  Single,  Married,  Divorced,  Widowed,  Separated

Name of spouse or significant other

Children: Number of Children Number of grandchildren

Women: Number of pregnancies , Number of deliveries - Vaginal , C-sections , Miscarriages , VIPs (abortions)

**Cancer health habits:** (Circle response)

|  |  |
| --- | --- |
| **Women**  Breast: Monthly self-exam Y N Yearly physician exam Y N  Last mammogram Y N  GYN: Yearly GYN exam Y N  Yearly PAP exam Y N | **Men**  Prostate: Yearly rectal exam Y N Yearly PSA blood test Y N |
| **All**  Skin: High sun exposure Y N  Yearly skin exam Y N | Colon: Yearly rectal exam Y N Yearly stool test for blood Y N Date of last colonoscopy |

**Review of Systems:** Do you currently have any of the following symptoms or conditions (Check if yes)

|  |  |
| --- | --- |
| **General:**  Nothing in this group   Weight loss – How much lbs   Loss of Appetite   Fever   Chills   Night Sweats   Fainting Spells  **Eyes:**  Nothing in this group   Eye disease or injury   Wear glasses or contacts   Blurred or double vision  **Ear, Nose, Mouth, Throat:**  Nothing in this group   Hearing loss   Ear ache / infection   Ringing in ears   Nose Bleeds   Bleeding gums   Mouth sores   Sore throat   Recent voice change   Runny nose / cold   Sinus problems   Neck stiffness / pain   Enlarged neck glands / masses | **Cardiovascular:**  Nothing in this group   Chest pain   Palpitations   Heart valve problems   Calf pain with walking   Leg swelling  **Respiratory:**  Nothing in this group   Chronic cough   Coughing up blood   Short of breath with activity   Short of breath lying flat   Wheezing   Asthma   Bronchitis   Pneumonia  **Musculoskeletal:**  Nothing in this group   Joint pain   rthritis   Back pain   Muscle weakness   Leg pain with walking   Leg pain at rest   Broken bones |

|  |  |
| --- | --- |
| **Digestive:**  Nothing in this group   Loss of appetite   Difficulty swallowing   Early satiety (fill up easy)   Heartburn   Nausea   Vomiting   Diarrhea   Constipation   Blood in stool   Dark, tarry stools   Abdominal pain   Painful bowel movements   Poor control of BMs, urgency  **Urinary:**  Nothing in this group   Burning with urination   Weak urine stream   Blood in urine   Gas or stool in urine   Poor control, leakage of urine   Kidney stones   Prostate problems   Testicular mass   Get up at night to urinate - Number of times per night | **Neurological:**  Nothing in this group   Frequent headaches   Migraines   Weakness   Seizures   Stroke   Paralysis   Decreased sensation   Difficulty with speech   Dizziness  **Psychiatric:**  Nothing in this group   Anxiety   Depression   Mood swings   Phobias, fears   Panic attacks   Suicide thoughts or attempts  **Endocrine:**  Nothing in this group   Heat or cold intolerance   Excessive thirst   Excessive urination   Excessive Sweating |
| **Gynecologic (female):**  Nothing in this group   Irregular periods - Last period:   Abnormal vaginal discharge  **Breast:**  Nothing in this group   Breast lump   Breast pain   Nipple discharge  **Skin:**  Nothing in this group   Rash   Skin infections   Ulcers or sores   Yellowing of the skin   Eczema, psoriasis, other   Pyoderma gangrenosum, erythema nodosum | **Hematologic, Lymphatic:**  Nothing in this group   Prior blood transfusion   Easy bleeding or bruising   Low red blood cell count (anemia)   Low white blood cell count   Prolonged bleeding with cuts, surgery   Swollen glands   Blood clots   Use of blood thinners   Swollen lymph nodes  **Allergic, Immunologic:**  Nothing in this group   HIV infection   Hepatitis   Imune deficiency   Antibiotics needed for dental work |