# 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, LymphomaOther  |  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 NLast mammogram Y NGYN: Yearly GYN exam Y NYearly PAP exam Y N | **Men**Prostate: Yearly rectal exam Y N Yearly PSA blood test Y N |
| **All**Skin: High sun exposure Y NYearly 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 |