

# NEW PATIENT MEDICAL HISTORY FORM

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

## ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

## MEDICATIONS

MEDICATIONS <i>(Please list ALL current medications or provide Medication bottles to nurse for review)</i>	DOSE <i>(Mg., pill, etc.)</i>	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

<b>CHOLESTEROL</b>	Date:	Facility/Provider:	Abnormal Result? Y N
<b>COLONOSCOPY/SIGMOID</b>	Date:	Facility/Provider:	Abnormal Result? Y N
<b>MAMMOGRAM</b>	Date:	Facility/Provider:	Abnormal Result? Y N
<b>PAP SMEAR</b>	Date:	Facility/Provider:	Abnormal Result? Y N
<b>BONE DENSITY</b>	Date:	Facility/Provider:	Abnormal Result? Y N

## VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax ( <i>Pneumonia</i> ):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine ( <i>Shingles</i> ):	

## PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer ( <i>type: _____</i> )			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes ( <i>type: _____</i> )			
Emphysema ( <i>COPD</i> )			
Heart Disease			
High Blood Pressure ( <i>hypertension</i> )			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal ( <i>kidney</i> ) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

## SURGERIES

TYPE ( <i>specify left/right</i> )	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: \_\_\_\_\_

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

<b>✓ CHECK ALL THAT APPLY</b>	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																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Other: _____																		

**SOCIAL HISTORY**

Occupation (or prior occupation):	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> LOA <input type="checkbox"/> Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift?   Y   N   N/A	
Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____	
Do you have children?   Y   N	If yes, how many?

**OTHER HEALTH ISSUES**

<b>TOBACCO USE</b>	Smoke Cigarettes?   Y   N   (If you never smoked, please move to Alcohol /Drug Use)		
<b>Current:</b> Packs/day _____ # of Years _____	<b>Past:</b> Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco (check one): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew			
<b>ALCOHOL/DRUG USE</b>	Do you drink alcohol?   Y   N	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> 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...*

<b>SEXUAL ACTIVITY</b>	Sexually involved currently? Y N <i>(If no sexual history, please move to Exercise section)</i>	
Sexual partner(s) is/are/have been: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth control method: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill/Ring/Patch/Inj/IUD <input type="checkbox"/> Vasectomy		
<b>EXERCISE</b>	Do you exercise regularly? Y N <i>(If you answered no, please move to Sleep)</i>	
What kind of exercise?		<b>Duration:</b> How long (min.): _____ How often: _____
<b>SLEEP</b>	How many hours, on average, do you sleep at night <i>(or during the day, if working night shift)</i> ?	
<b>DIET</b>	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Would you like advice on your diet? Y N
<b>SAFETY</b>	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		
Eye Doctor		
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?

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

CONSTITUTION		CARDIOVASCULAR		SKIN	
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash
	Diaphoresis	<b>Gastrointestinal</b>			Wound
	Fatigue		Abdominal distention	<b>ALLERGY/IMMUNO</b>	
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
<b>HEAD, EAR, NOSE &amp; THROAT</b>			Blood in stool		Immunocompromised
	Congestion		Constipation	<b>NEUROLOGICAL</b>	
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling	<b>ENDOCRINE</b>			Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnasal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure	<b>Genitourinary</b>		<b>HEMATOLOGIC</b>	
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis	<b>PSYCHIATRIC</b>	
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
<b>EYES</b>			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
<b>RESPIRATORY</b>			Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness	<b>MUSCULAR</b>			
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

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