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

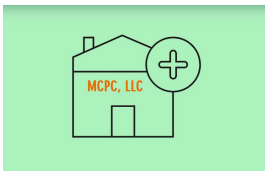
If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

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

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	



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:			

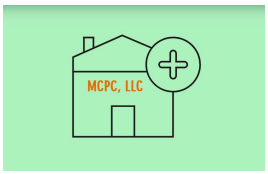
SURGERIES

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: _____



FAMILY MEDICAL HISTORY ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

Mother :
Father :
Siblings :
Children :
Grandparents :

Other Family History:

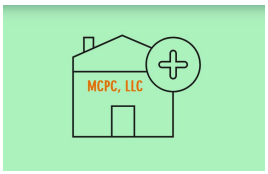
SOCIAL HISTORY

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	
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 ☐ Tubal Ligation		
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

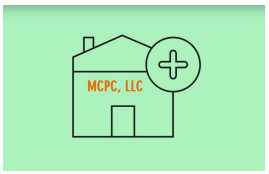
OTHER PROVIDERS/SPECIALISTS

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?	If yes, how long and what branch?
Were you deployed?	If yes, where?

Patient Name: _____ DOB: _____



REVIEW OF SYSTEMS **ENTER X FOR ALL THAT APPLY**

	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		

Patient Name: _____ DOB: _____