NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

HEALTH MAINTENANCE SCREENING TEST HISTORY

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 Alcoholism/Drug Abuse	CURRENT	PAST	COMMENTS
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:	

FAMILY MEDICAL HISTORY

	Depression/Anxiety	*Asthma*	*Cancer (type:_____*	*Emphysema*	*(COPD)*	*Bipolar/Suicidal*	*Diabetes*	*Early Death*	*Heart Disease*	*High Cholesterol*	*High Blood Pressure*	*Kidney Disease*	*Stroke*	*Thyroid Disease*	*M igraines*	*O ther :_____*	*O ther :_____*	*O ther :_____*
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
O ther :_____																		

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)*: 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			

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST vISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
O ther :_____		
O ther :_____		

REVIEW OF SYSTEMS

ChECK ALL ThAT APPLY

CONSTITUTION	CARDIOvASCULAR	SKIN
Activity change Appetite	Chest pain	Color change
change Chills Diaphoresis	Leg swelling	Pallor Rash
Fatigue Fever Unexpected	Palpitations	Wound
weight change	**Gastrointestinal**	
	Abdominal distention	**ALLERGY/IMMUNO**
	Abdominal pain	Environmental allergies
	Constipation	Food allergies
hEAD, EAR, NOSE & ThROAT	Diarrhea	Immunocompromised
Congestion	Nausea	**NEUROLOGICAL**
Dental problem	Vomiting	Dizziness
Drooling	Blood in stool	Facial asymmetry
Ear discharge		Headaches
Ear pain		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	D ysuria Enuresis	Bruises/bleeds
Tinnitus	Flank pain	easily **PSYChIATRIC**
Trouble swallowing	Frequency Genital	Agitation
Voice change	sore Hematuria	Behavior problem
EYES	Penile discharge	Confusion
Eye discharge	Penile pain Penile	Decreased concentration
Eye itching	swelling Scrotal	Dysphoric mood
Eye pain	swelling Testicular	Hallucinations
Eye redness	pain Urgency Urine	H yperac tive
Photophobia	decreased	Ner vous/anxious
Visual disturbance		Self-injury
RESPIRATORY		Sleep disturbance
Apnea		Suicidal ideas
Chest tightness	**MUSCULAR**	
Choking	Ar thralgias	
Cough	Back pain	
Shortness of breath	Gait problems	
Stridor	Joint swelling	
Wheezing	Myalgias	
	Neck pain	
	Neck stiffness	

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____