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***NEW PATIENT MEDICAL HISTORY***

**Date**\_\_\_/\_\_\_/\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Marital Status:** Married / Single / Divorced / Widowed **(please circle)**

**PLEASE COMPLETE ALL PAGES- IF YOU ARE UNSURE OF EXACT DATES ESTIMATES WILL BE FINE.**

**Reason for your visit today:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATIONS: Please list ALL medications- prescription and over the counter medications (example: natural remedies, vitamins, Tylenol, etc.) Use back if more space is needed**

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| **Medication**  *Ex: Tylenol* | **Dosage**  *Ex: 500mg* | **Frequency**  *Ex: 1 3x day* | | **Started month/yr**  *Ex 12/2013* | **Prescribed by:**  *Ex: Dr Smith* |
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| **Medication or Food Allergy (ex: cipro) use back if needed** | | | **Type of reaction (ex: rash)** | | |
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| **Pharmacy** | **Address** | **Phone Number** |
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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History: (please check mark)**

Allergies \_\_\_\_ Hepatitis: A\_\_\_\_ B\_\_\_\_ C \_\_\_\_

Anemia \_\_\_\_ Kidney Disease \_\_\_\_

Angina (chest pain) \_\_\_\_ Liver Disease \_\_\_\_

Anxiety \_\_\_\_ Migraines \_\_\_\_

Arthritis \_\_\_\_ Osteoporosis \_\_\_\_

Asthma \_\_\_\_ Prostate Enlarged

Atrial Fibrillation \_\_\_\_ Seizures \_\_\_\_

Bleeding Disorder \_\_\_\_ Sleep Apnea \_\_\_\_

Blood Clots \_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ (type) Year Diagnosed \_\_\_\_\_\_ Skin Disorders \_\_\_\_

COPD \_\_\_\_ Stroke \_\_\_\_

Crohn’s Disease \_\_\_\_ Thyroid Disease \_\_\_\_

Depression \_\_\_\_ Ulcers \_\_\_\_

Diabetes Type 1 \_\_\_\_ Type 2 \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GERD (acid reflux) \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Attack \_\_\_ Year \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease: CHF \_\_\_ Other \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure \_\_\_\_

**SURGICAL HISTORY:** (Gallbladder, Tonsils, Appendix, Hysterectomy, etc)

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| **Surgery Type:** | **Physician/Surgeon** | **Date :**  **month/year** | **Location/Hospital** |
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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

**1. Do you smoke?** ( ) No, I have never smoked.

( ) Yes, I smoke \_\_\_ packs of cigarettes a day for \_\_\_ yrs.

( ) No, I quit smoking \_\_\_ yrs. ago. I smoked \_\_\_ packs a day for \_\_\_ yrs.

( ) Yes, I smoke cigars or a pipe, \_\_\_ a day for \_\_\_ yrs.

( ) Yes, I use snuff \_\_\_\_ times a day or \_\_\_\_ times a week or only on

Occasion \_\_\_\_\_\_\_\_\_.

**2. Do you drink alcoholic beverages?**

( ) Beer \_\_\_\_ cans per day / week / month / year (circle one)

( ) Wine\_\_\_\_ glasses per day/ week / month / year (circle one)

( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**3. How much caffeine do you drink on a daily basis: (coffee, tea, colas)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**4. Have you ever used illicit drugs (marijuana, meth, heroin, cocaine, LSD, etc)?** Yes / No

Currently using / Used in the past (circle one) Last used **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. Have you ever used illicit drugs intravenously?** Yes / No

**If yes please list illicit drugs that are/ or were used:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are you sexually active?** Yes / No **Are your partners** male / female / or both? **(Please circle)**

**Do you use contraception?** None Condoms Pill Vasectomy IUD Diaphragm Tubal Ligation **(please circle)**

**Do you practice safe sex?** Never / Sometimes / Always **(please circle)**

**For Woman Only:**

Number of pregnancies: \_\_\_\_\_

Number of live births: \_\_\_\_\_

Number of abortions/miscarriages: \_\_\_\_\_

**Date of your last period? \_\_\_/\_\_\_\_/\_\_\_\_**

**What is your occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Please check if the following pertain to safety behaviors you follow:**

( ) Wear Seatbelt ( ) Wear helmet while riding bike or motorcycle

( ) Smoke detector in home ( ) Fire extinguisher in home

( ) Guns in the home ( ) Guns are kept locked up at all times

**Do you have advanced directives?** Yes / No

Living Will Durable Power of Attorney for medical decisions **(please circle one)**

**If No, would you like information regarding advanced directives?** Yes No **(please circle one)**

**Do you have a signed DNR (Do Not Resuscitate)?** Yes No **(please circle one)**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY If adopted and you do not know your history check box □**

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| Relation | **Heart Disease** | **Diabetes** | **Lung**  **Disease** | **Cancer/Type** | **Stroke** | **High Cholesterol** | **High Blood Pressure** | **Mental Illness** | **Age(now or at death** |
| Mother |  |  |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |  |  |
| Maternal  Grandmother |  |  |  |  |  |  |  |  |  |
| Maternal  Grandfather |  |  |  |  |  |  |  |  |  |
| Paternal  Grandmother |  |  |  |  |  |  |  |  |  |
| Paternal  Grandfather |  |  |  |  |  |  |  |  |  |
| Siblings  Brother/Sister |  |  |  |  |  |  |  |  |  |
| Siblings  Brother/Sister |  |  |  |  |  |  |  |  |  |
| Siblings  Brother/Sister |  |  |  |  |  |  |  |  |  |
| Siblings  Brother/Sister |  |  |  |  |  |  |  |  |  |

***Please List any other pertinent family history here:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any other physicians or health care providers you see (specialist, therapists, counselors, chiropractors, eye doctors, etc)**

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Maintenance**

**Please write the approximate dates of the most recent tests you have completed**

\_\_\_/\_\_\_/\_\_\_ Bone Density Screening (osteoporosis) \_\_\_/\_\_\_/\_\_\_ Colonoscopy/EGD

\_\_\_/\_\_\_/\_\_\_ Cardiac Stress Test \_\_\_/\_\_\_/\_\_\_ EKG

\_\_\_/\_\_\_/\_\_\_ Pap Smear \_\_\_/\_\_\_/\_\_\_ Diabetic A1C Lab Test

\_\_\_/\_\_\_/\_\_\_ Cholesterol/Lipid labs \_\_\_/\_\_\_/\_\_\_ Diabetic Foot Exam

\_\_\_/\_\_\_/\_\_\_ Chest X-Ray \_\_\_/\_\_\_/\_\_\_ Prostate exam

\_\_\_/\_\_\_/\_\_\_ CT/MRI (If yes what body area- brain, back, legs, arms, other-please circle)

\_\_\_/\_\_\_/\_\_\_ Mammogram/Breast- if abnormal please give details:

\_\_\_/\_\_\_/\_\_\_ Ultrasound (if yes what kind)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_ Eye Exam

**Check Mark each immunization that you have had:**

\_\_\_ Hepatitis A Date: \_\_\_/\_\_\_/\_\_\_

\_\_\_ Hepatitis B Date: 1.) \_\_\_/\_\_\_/\_\_\_, 2.) \_\_\_/\_\_\_/\_\_\_, 3.) \_\_\_/\_\_\_/\_\_\_

\_\_\_ Tetanus Shot Date: \_\_\_/\_\_\_/\_\_\_ (Was pertussis included –TDAP)? Yes / No (circle one)

\_\_\_ Influenza (flu) Date: \_\_\_/\_\_\_/\_\_\_ \_\_\_ Rubella Date: \_\_\_/\_\_\_/\_\_\_

\_\_\_ Pneumonia Date: \_\_\_/\_\_\_/\_\_\_ \_\_\_ Zostavax Date: \_\_\_/\_\_\_/\_\_\_

(Shingles Vaccine)

\_\_\_ Measles Date: \_\_\_/\_\_\_/\_\_\_ \_\_\_Flu Vaccine Date: \_\_\_/\_\_\_/\_\_\_

\_\_\_ HPV (3 shots) Date 1.) \_\_\_/\_\_\_/\_\_\_ 2.) \_\_\_/\_\_\_/\_\_\_/ 3.) \_\_\_/\_\_\_/\_\_\_.

\_\_\_ Varicella(Chicken pox) Date: \_\_\_/\_\_\_/\_\_\_

**Do you have a Pacemaker** YES / NO Please give copy of ID card

**Do you have a Defibrillator** YES / NO Please give copy of ID card

**Do you have Stents** YES / NO Please give copy of ID card

**Do you have any metal in your body** YES / NO Please give copy of ID card

**Other Implants:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_