NORTHSIDE
FAMILY MEDICINE
OF JOHNS CREEK
A Northside Network Provider

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Name: _____ DOB: _____ Today's date: _____

Person completing form (if other than patient): _____ Relationship: _____

Past Medical History *(Please check all that apply)*

☐ Acid Reflux/GERD	☐ Coronary Artery Disease	☐ HIV or AIDS	☐ Osteoporosis
☐ Anxiety Disorder	☐ Depression	☐ High Cholesterol	☐ Seizure
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Sleep Apnea
☐ Asthma	☐ Diverticulitis	☐ Thyroid Problem	☐ Stroke
☐ Bipolar Disorders	☐ Fibromyalgia	☐ Kidney Disease	☐ Tuberculosis
☐ Bleeding Disorder	☐ Gout	☐ Kidney Stones	☐ Other:
☐ Blood Clots (DVT or PE)	☐ Heart Attack	☐ Leg/Foot Ulcers	☐ Other:
☐ Cancer:	☐ Heart Murmur/Valve Problem	☐ Liver Disease	☐ Other:
☐ COPD	☐ Hepatitis C	☐ Migraines	☐ Other:

Surgical History	Year		Year
☐ Appendix Removed		☐ Hernia Repair (Type: _____)	
☐ Back Surgery		☐ Hysterectomy: Partial or Complete	
☐ Bladder Surgery		☐ Orthopedic Surgery	
☐ Cataract		☐ Tonsils Removed	
☐ C Section		☐ Tubal Ligation	
☐ Ear Tubes		☐ Vasectomy	
☐ Heart Catheterization:		☐ Other:	
☐ Gallbladder Removal		☐ Other:	
☐ Heart Bypass		☐ Other:	

Past Hospitalizations

☐ No Previous Hospitalizations

Year	Reason	Hospital

ADULT NEW PATIENT FORM

List Other Doctors You See

Family History

	Alive?	Age?	Alcoholism/ Substance Abuse	Cancer	Cholesterol	Diabetes	Depression/ Anxiety	Heart Disease	High Blood Pressure	Stroke	Thyroid Problems	Other (please list)
Mother	Y / N											
Father	Y / N											
Siblings	Y / N											
	Y / N											
	Y / N											
	Y / N											
Children	Y / N											
	Y / N											
	Y / N											
	Y / N											

Prescribed Drugs, Over-the-Counter Drugs, Herbals, and Supplements

Medication Name	Strength (mg)	Frequency Taken/ How Often

Medication and Food Allergies

Medication/Food	Type of Reaction	
		☐ No allergy to medication, food, latex or iodine

Health Maintenance

When was your last …	Please fill in date	Normal?	When was your last …	Please fill in date	Normal?
☐ Eye Exam		Y / N	☐ Mammogram		Y / N
☐ Colonoscopy		Y / N	☐ Bone Density		Y / N
☐ Cologuard		Y / N	☐ Pap Smear		Y / N

Immunizations	Date		Date
☐ Chicken pox		☐ Meningococcus	
☐ Covid		☐ MMR *(Measles, Mumps, Rubella)*	
☐ Flu Shot		☐ Pneumonia	
☐ Gardasil/HPV		☐ Shingrix *(Shingles)*	
☐ Hepatitis A		☐ Tdap *(Tetanus and pertussis)*	
☐ Hepatitis B		☐ Tetanus	

Obstetric and Gynecologic History *(Complete if applicable)*

Age of first menstrual period:	Sexually active? ☐ Yes ☐ No
Date of last menstrual period or age or menopause:	Current contraception:
Number of pregnancies: _____ births: _____ miscarriages: _____ abortions: _____	☐ condoms ☐ Nexplanon ☐ depo shot ☐ vasectomy ☐ pills/patch ☐ IUD ☐ tubal ligation ☐ none

Social History

Who lives in the home?

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Name / Relationship_____ Age ____ Occupation _____

Job Occupation _____ ☐ Retired

☐ Disabled If disabled, please list reason:

Alcohol	Do you drink alcohol? ☐ Yes ☐ No	(A drink is 1 shot of liquor, 1 glass of wine, or 1 bottle/can of beer.)
	How many per week? _____	Has anyone been concerned about your drinking? ☐ Yes ☐ No
Tobacco	Do/did you use tobacco? ☐ Yes ☐ No	Secondhand smoke exposure? ☐ Yes ☐ No
	Cigarettes - packs/day: _____	Number of years: _____ Year quit: _____
Drug Use ☐ Yes ☐ No ☐ Quit (date) _____		If yes, what do you use regularly? _____

Exercise Level

☐ None (No exercise) ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

Advanced Directives/Living Wills:

Do you have an advanced directive or a living will?	☐ Yes ☐ No
If yes, please give a copy to front desk.	
If no, would you like more information?	☐ Yes ☐ No