NORTHSIDE FAMILY MEDICINE PARTNERS
A Northside Network Provider

Patient Medical History

Date

Last name

First name Middle name

Street (mailing) address

City State Zip

Sex ☐ male ☐ female

Marital status ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated

Instructions

This information is for your *current* medical status. Please answer every question.

To ensure accurate interpretation, darken the entire box *accurately* and *completely* with a dark pen.

Example: ■ correct ☒ incorrect ☑ incorrect

Social history

Alcohol	☐ yes ☐ no	Smoking	☐ yes ☐ no
Sexually active	☐ yes ☐ no	Recreational drug use	☐ yes ☐ no
Exercise	☐ yes ☐ no	Caffeine	☐ yes ☐ no

Family history

Mother	☐ cancer	☐ high blood pressure	☐ heart disease
	☐ strokes	☐ mental disease	☐ alcohol or drug addiction
	☐ glaucoma	☐ bleeding disease	☐ diabetes
	☐ other (please specify)		
Siblings	☐ cancer	☐ high blood pressure	☐ heart disease
	☐ strokes	☐ mental disease	☐ alcohol or drug addiction
	☐ glaucoma	☐ bleeding disease	☐ diabetes
	☐ other (please specify)		
Children	☐ cancer	☐ high blood pressure	☐ heart disease
	☐ strokes	☐ mental disease	☐ alcohol or drug addiction
	☐ glaucoma	☐ bleeding disease	☐ diabetes
	☐ other (please specify)		
Father	☐ cancer	☐ high blood pressure	☐ heart disease
	☐ strokes	☐ mental disease	☐ alcohol or drug addiction
	☐ glaucoma	☐ bleeding disease	☐ diabetes
	☐ other (please specify)		

Current symptoms/complaints

Constitutional

Weight gain	☐ yes	☐ no	Loss of appetite	☐ yes	☐ no
Fever	☐ yes	☐ no	Weakness	☐ yes	☐ no
Breast feeding	☐ yes	☐ no	Weight loss	☐ yes	☐ no
Fatigue	☐ yes	☐ no	Reduced appetite	☐ yes	☐ no

HEENT (ENT)

Cold	☐ yes	☐ no	Cough	☐ yes	☐ no
Epistaxis (nose bleed)	☐ yes	☐ no	Hearing loss	☐ yes	☐ no
Change in voice	☐ yes	☐ no	Sore throat	☐ yes	☐ no
Ringing in ears	☐ yes	☐ no	Sinus pain	☐ yes	☐ no
Ear fullness	☐ yes	☐ no	Itchy eyes	☐ yes	☐ no
Runny nose	☐ yes	☐ no	Scratchy throat	☐ yes	☐ no
Sinus congestion	☐ yes	☐ no			

Respiratory

Shortness of breath	☐ yes	☐ no	Chest pain	☐ yes	☐ no
Chest congestion	☐ yes	☐ no	Cough	☐ yes	☐ no

Cardiology

Dizziness	☐ yes	☐ no	Chest pain	☐ yes	☐ no
Palpitations	☐ yes	☐ no	Leg edema	☐ yes	☐ no
Shortness of breath	☐ yes	☐ no	Varicose veins	☐ yes	☐ no

Gastroenterology

Blood in stool	☐ yes	☐ no	Diarrhea	☐ yes	☐ no
Vomiting	☐ yes	☐ no	Constipation	☐ yes	☐ no
Nausea	☐ yes	☐ no	Trouble swallowing	☐ yes	☐ no
Abdominal pain	☐ yes	☐ no	Heartburn	☐ yes	☐ no
Hemorrhoids	☐ yes	☐ no			

Female reproductive

Hot flashes	☐ yes	☐ no	Abnormal vaginal discharge	☐ yes	☐ no
Heavy periods	☐ yes	☐ no	Painful intercourse	☐ yes	☐ no
Sexually active	☐ yes	☐ no	Painful periods	☐ yes	☐ no
Infertility	☐ yes	☐ no	Frequent yeast infections	☐ yes	☐ no
Pelvic pain	☐ yes	☐ no	Breast pain	☐ yes	☐ no
Nipple discharge	☐ yes	☐ no	Birth control	☐ yes	☐ no
Menopause	☐ yes	☐ no			

Male reproductive

Difficulty with erection	☐ yes	☐ no	Diminished sexual drive	☐ yes	☐ no
Penile discharge	☐ yes	☐ no	Contraception	☐ yes	☐ no

Musculoskeletal

Joint stiffness	☐ yes	☐ no	Leg cramps	☐ yes	☐ no
Joint pain	☐ yes	☐ no	Joint swelling	☐ yes	☐ no
Sciatica	☐ yes	☐ no	Osteoporosis treatment	☐ yes	☐ no
Fracture	☐ yes	☐ no	Carpal tunnel	☐ yes	☐ no

Hematology/lymph

Swollen glands	☐ yes	☐ no	Fatigue	☐ yes	☐ no
Loss of appetite	☐ yes	☐ no	Varicose veins	☐ yes	☐ no
Easy bruising	☐ yes	☐ no			

Dermatology

Rash	☐ yes	☐ no	Mole	☐ yes	☐ no
Lumps	☐ yes	☐ no	Dry or sensitive skin	☐ yes	☐ no
Hives	☐ yes	☐ no	Acne	☐ yes	☐ no
Skin cancer	☐ yes	☐ no			

Neurology

Headache	☐ yes	☐ no	Tingling numbness	☐ yes	☐ no
Seizures	☐ yes	☐ no	Insomnia	☐ yes	☐ no
Memory loss	☐ yes	☐ no	Dizziness	☐ yes	☐ no
Gait abnormality	☐ yes	☐ no			

Psychology

Depression	☐ yes	☐ no	High stress level	☐ yes	☐ no
Sleep disturbances	☐ yes	☐ no	Suicidal ideation	☐ yes	☐ no
Eating disorder	☐ yes	☐ no	Mental or physical abuse	☐ yes	☐ no
Anxiety	☐ yes	☐ no			

Opthalmology

Diminished vision	☐ yes	☐ no	Eye irritation	☐ yes	☐ no
Drainage from eyes	☐ yes	☐ no	Blurring of vision	☐ yes	☐ no
Seasonal eye symptoms	☐ yes	☐ no	Loss of vision	☐ yes	☐ no

Urology

Difficulty urinating	☐ yes	☐ no	Blood in urine	☐ yes	☐ no
Frequent urination	☐ yes	☐ no	Urinary incontinence (leakage)	☐ yes	☐ no
Recurrent UTI	☐ yes	☐ no	Nighttime urination	☐ yes	☐ no
Impotence	☐ yes	☐ no			

Endocrinology

Fatigue	☐ yes	☐ no	Thirst	☐ yes	☐ no
Excessive urination	☐ yes	☐ no	Weight loss	☐ yes	☐ no
Sleep disturbance	☐ yes	☐ no	Cold intolerance	☐ yes	☐ no
Heat intolerance	☐ yes	☐ no	Diabetes	☐ yes	☐ no

Allergies

Do you have allergies to any medications, x-ray dyes or other substances? ☐ yes ☐ no

If "yes," list names of substances and type of reactions.

Substance	Reaction

Current Medications

List any and all medications, including prescription, over-the-counter products, vitamins and herbs, etc.

Medication	Dose	Medication	Dose

Please list the following and the dates of occurrence

Operations

Procedure	*Date*

Hospitalizations other than surgery

Cause of hospitalization	*Date*

Immunization history

Hepatitis B	☐ yes	☐ no	Date
Pneumovax	☐ yes	☐ no	Date
Flu	☐ yes	☐ no	Date
Tetanus	☐ yes	☐ no	Date
Other (please specify)			Date
Other (please specify)			Date
Other (please specify)			Date

Date of your last...

Pap smear	Mammogram
Breast check	Cholesterol check
Stool check for blood	Prostate exam
Colonoscopy	Bone density

Thank you for filling out this important form and for choosing Northside Family Medicine Partners.