Full Name: ______________________ Date: ______________

Birth Date: ______________________ Age: ______________

FAMILY HISTORY: Please include age at death

	Father	Mother	Grandparents	Siblings
Alzheimer's Disease				
Asthma				
Bleeding Disorder				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Migraines				
Stroke				
Thyroid Disease				
Other:				

ALLERGIES:

Medication/Food/Other that causes allergy	Type of reaction (hives, swelling, etc.)?

CURRENT MEDICATIONS: Please list all current medications you are taking, including but not limited to: blood pressure medicine, heart medicine, diuretic (water) pill, diabetes medicine, thyroid medicine, pain medicine, nerve pill/ antidepressants, asthma medicine, hormones, herbal supplements, vitamins, etc.

HEALTH SCREENING:

Last Mammogram: ______________ Last Bone Density: ______________

Last Pap Smear: ______________ Last Colonoscopy: ______________

Diabetic Eye Exam: ______________

NEW PATIENT MEDICAL HISTORY FORM

Name: ______________________________ DOB: ______________________

PAST MEDICAL HISTORY: Check any problem you have been diagnosed with or received treatment for:

☐ Acid Reflux
☐ ADD/ADHD
☐ Allergies
☐ Anemia/Low Blood Counts
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bipolar Disorder/Manic-Depressive Disorder
☐ Bleeding Disorder
☐ Blood clot in legs/lungs
☐ Cancer
☐ Congestive Heart Failure
☐ COPD
☐ Depression
☐ Diabetes
☐ Glaucoma/Cataracts
☐ Gout
☐ Heart Attack
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol/Triglyceride
☐ HIV
☐ Kidney Disease/Stones
☐ Lupus
☐ Osteoporosis
☐ Pancreatitis/Inflamed pancreas
☐ Pneumonia
☐ Prostate Problems
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Skin Problems
☐ Stomach Ulcer
☐ Stroke
☐ Treated for irregular heartbeat
☐ Treated with blood thinner
☐ Tuberculosis

Other Conditions:

____

____

PAST SURGICAL PROCEDURES: (please list all and year)

SOCIAL HISTORY:

☐ Current Smoker: ____ packs/day for ____# of years
☐ Previous Smoker: Quit Date_________
☐ Smokeless Tobacco
☐ Pipe
☐ Cigars
☐ Vaping

☐ Married ☐ Divorced ☐ Single ☐ Widowed
☐ Do you drink alcohol? ☐ No ☐ Yes
If yes, how many drinks per day? ___________
☐ Use Illegal/Recreational Drugs: ☐ Past ☐ Present
☐ Average Hours of Sleep Per Night ____________
☐ Exercise ____ x/week

IMMUNIZATIONS: (please fill in date of your last)

Tetanus		Pneumonia shot	
Flu vaccine		Shingles vaccine	
Hepatitis B (set of 3)		Any others:	
Prevnar			

OTHER PROVIDERS/SPECIALISTS:

Doctor Name	Specialty	Phone number

Name: ______________________ DOB: ______________

To be answered by WOMEN only

Please circle Yes or No and explain yes answers.

Abnormal vaginal bleeding	YES	NO	______
Abnormal vaginal discharge	YES	NO	______
Vaginal dryness	YES	NO	______
Vaginal itching	YES	NO	______
Pain with having sex	YES	NO	______
Breast lump	YES	NO	______
Breast pain	YES	NO	______
Nipple discharge	YES	NO	______

To be answered by MEN only

Please circle Yes or No and explain yes answers.

Are you concerned about your sexual function?	YES	NO	______
If yes, do you have trouble getting/maintaining an erection?	YES	NO	______
Discharge from penis	YES	NO	______
Have you ever been treated for difficultly getting an erection?	YES	NO	______
Have you ever been treated for low testosterone?	YES	NO	______
Hernia (rupture)?	YES	NO	______
Prostate trouble?	YES	NO	______

Write in the names of any diseases you have had which required hospitalization:

____

____

Serious Illnesses which you have had: (not requiring hospitalization)

____

____

Serious injuries or accidents:

____

____

Name: ______________________________ DOB: ______________________

REVIEW OF SYSTEMS (Please verify if you have had any of the following within the last 30 days)
Please circle Yes or No and explain yes answers.

GENERAL

Fatigue, tiredness	YES NO	____________
Increased thirst or urination	YES NO	____________
Fever or chills	YES NO	____________
Any new lumps/bumps on the body	YES NO	____________
Unexplained weight loss	YES NO	____________
Unexplained weight gain	YES NO	____________
Night sweats	YES NO	____________
Difficulty with sleep	YES NO	____________

EYES

Changed vision	YES NO	____________
Red eye(s)	YES NO	____________
Dry eye(s)	YES NO	____________
Painful eye(s)	YES NO	____________
Spots/wavy lines	YES NO	____________
Flashes with eye movement	YES NO	____________
Flickering lights	YES NO	____________
Do you wear contacts	YES NO	____________

EARS, NOSE, AND THROAT

Bleeding from the nose	YES NO	____________
Snoring	YES NO	____________
Recurring sinus infections	YES NO	____________
Bothersome nasal allergies	YES NO	____________
Trouble breathing through your nose	YES NO	____________
Problems with taste or smell	YES NO	____________
Ringing in the ears	YES NO	____________

PSYCHIATRIC

Anxiety	YES NO	____________
Depression	YES NO	____________
Thoughts of hurting yourself	YES NO	____________
Thoughts of hurting others	YES NO	____________

MUSCULOSKELETAL

Neck pain	YES NO	____________
Back pain	YES NO	____________
Joint pain	YES NO	____________
Redness of swelling of any joints	YES NO	____________

URINARY

Pain with urination	YES NO	____________
Blood in urine	YES NO	____________
Urinating too frequently	YES NO	____________
Trouble with ease of urinary flow	YES NO	____________

SKIN

New moles	YES NO	____________
New rash	YES NO	____________
Psoriasis	YES NO	____________
Persistent itching	YES NO	____________
Sores/open wounds	YES NO	____________

CV

Chest Pain	YES NO	____________
Episode of rapid or irregular heartbeat	YES NO	____________
Swelling in legs/feet	YES NO	____________
Awakening at night because of shortness of breath	YES NO	____________

RESPIRATORY

Shortness of breath	YES NO	____________
Wheezing	YES NO	____________
Cough	YES NO	____________
Coughing up blood	YES NO	____________
Have you been told you stop breathing in your sleep	YES NO	____________

GI

Abdominal pain	YES NO	____________
Difficulty with swallowing	YES NO	____________
Pain with swallowing	YES NO	____________
Black stool	YES NO	____________
Blood in your stool	YES NO	____________
Constipation	YES NO	____________
Diarrhea	YES NO	____________
Vomiting	YES NO	____________
Nausea	YES NO	____________
Heartburn/Acid Reflux	YES NO	____________

NEUROLOGIC

Headaches	YES NO	____________
Fainting spells	YES NO	____________
Episodes of seizures	YES NO	____________
Vertigo/Room spinning	YES NO	____________
Frequent falling	YES NO	____________

HEMATOLOGIC

Abnormal bruising	YES NO	____________
Abnormal bleeding	YES NO	____________
Recurrent blood clots	YES NO	____________

Patient's Signature: ______________________________ **Date:** ______________