NEW PATIENT MEDICAL HISTORY FORM

Today's Date: _____

Patient's Name (First, Middle, Last): _____

Date of Birth: _____ /_____ /_____ Occupation: _____Years at Current Job: _____

Reason for Clinic Visit: _____

Please List Previous Healthcare Providers/Specialists: _____

_____

MEDICAL CONDITIONS

Do you have or have you had any of the following medical conditions/issues?

	Yes	No	*If yes, please describe*
Anxiety/Depression	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Blood Clots/Blood Disease	☐	☐	Location of Clots:
Cancer	☐	☐	Kind:
Chronic Pain	☐	☐	
Cirrhosis	☐	☐	
Congestive Heart Failure	☐	☐	
COPD	☐	☐	
Crohn's Disease	☐	☐	
Diabetes	☐	☐	Type:
Diverticulitis	☐	☐	
Epilepsy	☐	☐	
Gout	☐	☐	
Heart Attack / MI	☐	☐	
Hepatitis	☐	☐	Type: Treated? ☐ Yes ☐ No Date: _____
High Blood Pressure	☐	☐	
Kidney Condition	☐	☐	Kind:
Pneumonia	☐	☐	
Recurrent UTIs	☐	☐	
Stress	☐	☐	
Stroke	☐	☐	
Stomach Ulcer	☐	☐	
Thyroid	☐	☐	
Tuberculosis	☐	☐	Kind: Treated? ☐ Yes ☐ No
Ulcerative Colitis	☐	☐	
Other	☐	☐	

NEW PATIENT MEDICAL HISTORY FORM

ALLERGIES

Do you have any allergies? ○ Yes ○ No ***Please list all allergies (Include medications, foods, x-ray dyes)***

Allergy	Type of Reaction

MEDICATIONS

Are you currently taking any medications? ○ Yes ○ No **Attach extra sheet if necessary*

Please list all medications that you are currently taking (Include prescription, over the counter, herbal/vitamins)

Medication	Dose (mg)	How often	Reason for taking medication	Prescribed by:

PHARMACY – Please list Pharmacy most frequently used for prescriptions.

Name: _____ Phone #: _____

Fax #: _____ Address: _____

SURGERIES

Have you had any surgeries in your lifetime? ○ Yes ○ No **Attach extra sheet if necessary*

(i.e. appendix, gallbladder, hernia, heart surgery, orthopedic, hysterectomy, tonsils, vasectomy, EGD, Colonoscopy, etc.)

Type of Surgery	Date (approximate)	Hospital or city (if known)

PREVIOUS HOSPITALIZATIONS

Have you ever been hospitalized? ○ Yes ○ No **Attach extra sheet if necessary*

Reason for Hospital Stay	Date (approximate)	Hospital or city (if known)

NEW PATIENT MEDICAL HISTORY FORM

FAMILY HISTORY

	Mother	*Father*	*Sister*	*Brother*	*Grandparent*	
Asthma	☐	☐	☐	☐	☐	
Alcoholism	☐	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	☐	
Blood Clots	☐	☐	☐	☐	☐	Type:
Blood Disease	☐	☐	☐	☐	☐	Type:
Cancer	☐	☐	☐	☐	☐	Type:
Congestive Heart Failure	☐	☐	☐	☐	☐	
Crohn's Disease/ Ulcerative Colitis	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	Type:
Emphysema/COPD	☐	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	Type:
Liver Disease	☐	☐	☐	☐	☐	Type:
MS	☐	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	☐	Type:
Stroke	☐	☐	☐	☐	☐	Type:
Thyroid Disease	☐	☐	☐	☐	☐	Type:
Ulcer	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	

TOBACCO, ALCOHOL, & DRUG HISTORY

Smoking Tobacco Use: ☐Never ☐Former ☐Current: *How many cigarettes per day?* _____
Do you use any of these nicotine-containing products? Secondhand smoke exposure?
☐E-Cigarettes ☐Vaping products ☐Smokeless Tobacco ☐Other ☐ Yes ☐ No
Average amount per day: _____ If previous, what age did you stop? _____
Alcohol Use: ☐ Never ☐Former ☐Current: *Beer, Wine, or Liquor?* _____
If yes, how often do you have a drink containing alcohol?
☐ 1-2 per year ☐ 1-2 a month ☐ 1-2 per week ☐ 3-5 a week ☐ Daily ☐ Several per day
Have you previously been diagnosed with alcoholism? ☐ Yes ☐ No When? _____
If you drank alcohol previously, when did you stop? _____
Drug Use: Have you ever used recreational/IV drugs? ☐ Yes ☐ No
If yes, what type? _____ If previous, what age did you stop? _____

HEALTH MAINTENANCE AND IMMUNIZATIONS

Please check recent health maintenance/immunizations. Give month/year to the right *(if known)*.

Bone Density: _____ Influenza/Flu Shot: _____
Colonoscopy: _____ Physical Exam: _____
COVID-19 Vaccine: _____ Pneumonia Shot: _____
Eye Exam: _____ Shingles Shot: _____
Last Labs/Blood work: _____ Tetanus Shot: _____

***FEMALE Patients ONLY:**

Have you gone through menopause? ☐ Yes ☐ No Date of last menstrual period: _____
Menstrual problems: ☐ Irregular ☐ Heavy ☐ Inconsistent ☐ None
Date of last Pap Smear: _____ Any Abnormalities? ☐ Yes ☐ No _____
Date of last Mammogram: _____ Any Abnormalities? ☐ Yes ☐ No _____
Number of Pregnancies: _____ Number of live births: _____ Current birth control method: _____
Have you had a Hysterectomy? ☐Yes ☐No If yes: ☐ Partial ☐Total Why? _____

NEW PATIENT MEDICAL HISTORY FORM

***MALE Patients ONLY:**

Date of last PSA test: _____ Date of last rectal exam: _____

REVIEW OF SYSTEMS

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight loss/gain
- ☐ Other: _____

Cardiovascular
- ☐ Irregular heartbeat
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Fainting
- ☐ Difficulty lying flat
- ☐ Palpitations
- ☐ Murmur

Ear / Nose / Throat
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye dryness
- ☐ Eye pain
- ☐ Double vision
- ☐ Hearing loss
- ☐ Light sensitivity
- ☐ Nasal drainage
- ☐ Nose bleeds
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Sores in mouth/throat
- ☐ Snoring
- ☐ Voice change

Gastrointestinal
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Black tarry stools
- ☐ Diarrhea
- ☐ Jaundice
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Troubles swallowing
- ☐ Vomiting
- ☐ Change in Stool
- ☐ Heart Burn / Reflux

Hematologic
- ☐ Easy bruising
- ☐ Itching
- ☐ Swollen lymph node
- ☐ Other: _____

Immunologic
- ☐ Hives
- ☐ Eczema
- ☐ Hay Fever
- ☐ Other: _____

Metabolic/Endocrine
- ☐ Cold intolerance
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Other: _____

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Other: _____

Neurological
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors
- ☐ Other: _____

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Respiratory
- ☐ Chest Pain (Respiratory)
- ☐ Cough
- ☐ Coughing Blood
- ☐ Known TB exposure
- ☐ Shortness of Breath
- ☐ Wheezing

Skin / Hair (Integumentary)
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Hair loss
- ☐ Mole changes
- ☐ Skin lesion
- ☐ Other: _____

Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Pain with urination
- ☐ Abnormal Discharge
- ☐ Erectile Dysfunction
- ☐ Other

Female Patients
- ☐ Abnormal Pap
- ☐ Hot flashes
- ☐ Irregular menstrual cycle
- ☐ Painful menstrual cycle
- ☐ Vaginal discharge
- ☐ Other: _____

Male Patients
- ☐ Erectile dysfunction
- ☐ Penile discharge
- ☐ Sexual dysfunction
- ☐ Other: _____