NEW PATIENT

COMPLETE PATIENT MEDICAL HISTORY

Your name:
_____**Sex**_____**Birthdate**_____

REASON FOR YOUR VISIT TODAY (What problems are you seeing the doctor for today? For how long?

_____

_____

_____

PRIOR MEDICAL HISTORY

Have you ever had or currently have any of these problems?

Acne ___ Anemia ___ Arthritis ___ Asthma ___ Back pain ___Bleeding __ Blood clots ___ Blood transfusion _____Blood vessel surgery ___ Cataracts ___ Cancer ___ Diabetes ____ Diarrhea ____ Depression ____ Emphysema ____ Epilepsy ___Fainting ____ Fever or infections _____ Gall Stones __ Glaucoma ___ Gout ____Heart Attack ____ Heart Rhythm problem ____ Heart Failure ____ Heart Valve problem ____ Hepatitis _____ Hiatal Hernia _____ High Blood Pressure ____Impotence ____ Jaundice___ Kidney failure ____ Kidney Infections ____ Kidney Stones ____ Loss of urine/stool ____ Menstrual Problems _____ Paralysis ____ Prostate Problems _____ Pneumonia ___ Psoriasis _____ Rectal Bleeding ___ Seizures ____ Skin rashes ____ Stroke ____ Thyroid Problems _____ Tuberculosis __ Ulcers ____ Venereal Diseases ___ Any other concerns, please list: _____

PAST OPERATIONS

What operations have you had?

Type of Operation	When did it occur	Doctor or Hospital
_____	_____	_____
_____	_____	_____

FEMALE HISTORY

When did your periods begin? _____ how often are your periods? _____

Have you stopped having regular periods? _____If so, when? _____

Do you consider your periods normal? _____

Have you ever been pregnant? _____ how many times have you been pregnant? _____

Have you had any miscarriages? If so, when and how many? _____

How many children have you delivered? _____ Vaginal _____ C-Section _____

PAST FAMILY HISTORY

Please list the ages and health problems of the people listed. If they are no longer living, please give age at time of death and what did they die from?

Mother _____**Father** _____

Brother _____**Sister** _____

Spouse _____ **Children** _____

Maternal grandparents' _____ **Paternal grandparents'** _____

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THESE PROBLEMS? If so, who and at what age?

Heart _____ **Prostate Cancer**_____

Breast Cancer _____ **Skin cancer** _____

Colon cancer _____ **Diabetes** _____

Alcoholism _____ **Depression** _____ **Anxiety** _____

SOCIAL HISTORY

What is your occupation? _____ Do you smoke? _____If so, how many cigs/day? _____ For how long? _____ Quit? When? _____

Do you wear a seatbelt? _____Do you have smoke detectors in your home? _____

Do you drink caffeine? _____ How much and what type _____

Do you drink alcohol (beer, wine, hard liquor)? _____ If so, what and how much? _____

Have you ever used illegal drugs? _____ If so, what? _____ Are you currently using drugs? ___

If you are married, is it a happy marriage? _____ has anyone ever abused you? _____

Have you ever had a sexually transmitted disease such as Gonorrhea, AIDS, Chlamydia, and Herpes? _____

Do you exercise regularly? _____If so, what do you do and how often? _____

ALLERGIES TO MEDICATIONS/FOODS

Please list medicines, foods, plants, pets, and insects you are allergic to.

Allergy _____ Reaction _____

Allergy _____ Reaction _____

MEDICATIONS YOU PRESENTLY TAKE

Please list all the medicines that you take. This includes those medicines from a doctor and those you buy at the store (also herbals).

Medicine _____Dosage_____

Medicine _____Dosage _____

Medicine _____ Dosage _____

Medicine _____Dosage _____

Medicine _____Dosage _____

Medicine _____ Dosage _____

PRIOR SHOTS/TESTS/VACCINES

Please check the vaccines and tests you've had and when you had them done.

Tetanus _____Flu shot _____Pneumonia_____Shingles _____

PAP Smear _____Mammogram _____Cholesterol level _____

Bone Density Scan _____ Colonoscopy _____

REVIEW OF PROBLEMS

Do you have any of the following problems?

Weight gain/loss _____ Heart burn _____ Tiredness _____ Stomach pain _____

Sadness _____ Problems with Sleep _____ Dizziness _____ Headaches _____

Eye or ear problems _____Nose/sinus problems _____ Breast problems _____

Chest pain _____ Breathing problems _____ Cough _____ Nausea _____

Diarrhea/constipation _____ Knee or hip pain _____ Weakness/tingling/numbness _____

Urination problems _____ Abnormal periods _____ any other issues _____

Other Comments:

Do you have any other comments and/or health concerns that you would like to discuss with the health care provider?

_____

_____

_____

_____

Patient signature _____Date _____

Provider reviewed_____ Date_____