

NEW PATIENT MEDICAL HISTORY FORM

Full Name: John Doe Date: _____
Birth Date: 04/23/1985 Age: 39

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION
Penicillin	Rash, Swelling
Pollen	Sneezing, Itchy Eyes

MEDICATIONS

MEDICATIONS <small>(Please list ALL)</small>	DOSE <small>(Mg., pill, etc.)</small>	TIMES PER DAY
Ibuprofen	200mg	3
Lisinopril	10mg	1
Metformin	500mg	2

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date: 01/15/2024	Facility/Provider: Health Clinic	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date: 12/10/2023	Facility/Provider: City Hospital	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date: 09/10/2023	Facility/Provider: Health Wellness	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or Tdap: 04/12/2022	Last Pnuemovax (Pneumonia): 11/08/2020
Last Flu Vaccine: 10/05/2023	Last Prevnar: 12/10/2021
Last Zoster Vaccine (Shingles): 07/21/2022	

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma	Yes		Mild, occasional use of inhaler
Cancer (type: _____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: <u>2</u> _____)	Yes		Diagnosed in 2020, on Metformin
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)	Yes		Controlled with medication
High Cholesterol	Yes		Under control with diet
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease			
Migraine Headaches	Yes		Treated with pain relievers
Stroke			
Other:			
Other:			

SURGERIES

TYPE (specify left/right)	DATE	LOCATION/FACILITY
Appendectomy	03/10/2010	General Hospital

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____

DOB: _____

FAMILY MEDICAL HISTORY ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type: _____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: _____	Other: _____	Other: _____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other: _____																		

SOCIAL HISTORY

Text

Occupation (or prior occupation):	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> LOA <input type="checkbox"/> Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N (If you never smoked, please move to Alcohol /Drug Use)		
Current: Packs/day _____ # of Years _____	Past: Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco (check one): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	<input checked="" type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor	# of Drinks/week: 3
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

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OTHER HEALTH ISSUES *continued...*

SEXUAL ACTIVITY	Sexually involved currently? <input checked="" type="radio"/> Y <input type="radio"/> N <i>(If no sexual history, please continue to Exercise)</i>	
Sexual partner(s) is/are/have been: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		
Birth control method: <input type="checkbox"/> None <input checked="" type="checkbox"/> Condom <input type="checkbox"/> Pill/Ring/Patch/Inj/IUD <input type="checkbox"/> Vasectomy		
EXERCISE	Do you exercise regularly? <input type="radio"/> Y <input type="radio"/> N <i>(If you answered no, please move to Sleep)</i>	
What kind of exercise?		Duration: How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night <i>(or during the day, if working night shift)</i> ?	
DIET	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Would you like advice on your diet? <input type="radio"/> Y <input type="radio"/> N
SAFETY	Do you use a bike helmet? <input type="radio"/> Y <input type="radio"/> N	Do you use seat belts consistently? <input type="radio"/> Y <input type="radio"/> N
Working smoke detector in home? <input type="radio"/> Y <input type="radio"/> N		If you have guns at home, are they locked up? <input type="radio"/> Y <input type="radio"/> N
Is violence at home a concern for you? <input type="radio"/> Y <input type="radio"/> N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? <input type="radio"/> Y <input type="radio"/> N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology	Dr. Smith	05/15/2024
Gastroenterologist (GI)	Dr. Lee	07/18/2023
OB/GYN		
Neurology		
Pulmonary	Dr. Garcia	02/10/2024
Other: _____		
Other: _____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? <input type="radio"/> Y <input type="radio"/> N	If yes, where?
Have you served in the military? <input type="radio"/> Y <input type="radio"/> N	If yes, how long and what branch?
Were you deployed? <input type="radio"/> Y <input type="radio"/> N	If yes, where?

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REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

CONSTITUTION		CARDIOVASCULAR		SKIN	
<input type="checkbox"/>	Activity change	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Color change
<input type="checkbox"/>	Appetite change	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	Pallor
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Diaphoresis	Gastrointestinal		<input type="checkbox"/>	Wound
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Abdominal distention	ALLERGY/IMMUNO	
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Environmental allergies
<input type="checkbox"/>	Unexpected weight change	<input type="checkbox"/>	Anal bleeding	<input type="checkbox"/>	Food allergies
HEAD, EAR, NOSE & THROAT		<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	Immunocompromised
<input type="checkbox"/>	Congestion	<input type="checkbox"/>	Constipation	NEUROLOGICAL	
<input type="checkbox"/>	Dental problem	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Drooling	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Facial asymmetry
<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Light-headedness
<input type="checkbox"/>	Facial swelling	ENDOCRINE		<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>	Heat intolerance	<input type="checkbox"/>	Speech difficulty
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Polydipsia	<input type="checkbox"/>	Syncope
<input type="checkbox"/>	Postnasal drip	<input type="checkbox"/>	Polyphagia	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	Rhinorrhea	<input type="checkbox"/>	Polyuria	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Sinus pressure	Genitourinary		HEMATOLOGIC	
<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	Adenopathy
<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Dysuria	<input type="checkbox"/>	Bruises/bleeds easily
<input type="checkbox"/>	Tinnitus	<input type="checkbox"/>	Enuresis	PSYCHIATRIC	
<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	Flank pain	<input type="checkbox"/>	Agitation
<input type="checkbox"/>	Voice change	<input type="checkbox"/>	Frequency	<input type="checkbox"/>	Behavior problem
EYES		<input type="checkbox"/>	Genital sore	<input type="checkbox"/>	Confusion
<input type="checkbox"/>	Eye discharge	<input type="checkbox"/>	Hematuria	<input type="checkbox"/>	Decreased concentration
<input type="checkbox"/>	Eye itching	<input type="checkbox"/>	Penile discharge	<input type="checkbox"/>	Dysphoric mood
<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	Penile pain	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	Eye redness	<input type="checkbox"/>	Penile swelling	<input type="checkbox"/>	Hyperactive
<input type="checkbox"/>	Photophobia	<input type="checkbox"/>	Scrotal swelling	<input type="checkbox"/>	Nervous/anxious
<input type="checkbox"/>	Visual disturbance	<input type="checkbox"/>	Testicular pain	<input type="checkbox"/>	Self-injury
RESPIRATORY		<input type="checkbox"/>	Urgency	<input type="checkbox"/>	Sleep disturbance
<input type="checkbox"/>	Apnea	<input type="checkbox"/>	Urine decreased	<input type="checkbox"/>	Suicidal ideas
<input type="checkbox"/>	Chest tightness	MUSCULAR			
<input type="checkbox"/>	Choking	<input type="checkbox"/>	Arthralgias		
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Back pain		
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Gait problems		
<input type="checkbox"/>	Stridor	<input type="checkbox"/>	Joint swelling		
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Myalgias		
<input type="checkbox"/>		<input type="checkbox"/>	Neck pain		
<input type="checkbox"/>		<input type="checkbox"/>	Neck stiffness		

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