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New Patient Medical History

Name_____DOB_____

This is a confidential record of your medical history and will be kept in your chart.

Patient History Information
Have you ever had or suffer from any of the following:

__ High Blood Pressure	__ Congestive Heart Failure	__ Reflux
__ Diabetes Mellitus	__ Angina Pectoris	__ Peptic Ulcer Disease
__ High Cholesterol	__ Valvular Heart Disease	__ Diverticulosis
__ Thyroid Disease	__ Atrial Fibrillation	__ Hemorrhoids
__ Stroke	__ Irregular Heart Beat	__ Kidney Disease
__ Migraines	__ Asthma	__ Anemia
__ Arthritis	__ Tuberculosis	__ Cancer
__ COPD	__ Pneumonia	__ Bleeding Abnormality
__ Heart Attack	__ Bronchitis	__ Kidney Stones
__ Depression	__ Liver Disease	__ Seizures
__ Glaucoma	__ Prostate Disease	__ Urinary Infection

Current Medications:

_____

_____

Hospitalizations:

_____

Surgeries (Type & Date):

_____

_____

Social History

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed Number of children: _____
Occupation:

_____

Do you smoke cigarettes? ___ Yes ___ No How many packs per day? _____ How long have you smoked? _____
Have you ever smoked in the past? ____Yes ____No If yes, for how long?_____Want to quit? _____Yes_____No
Do you chew tobacco or snuff? ___ Yes ___ No How long have you used oral tobacco? _____How much?_____
Do you drink alcoholic beverages? ___ Yes ___ No Type: ___ Beer ___ Wine ___ Liquor ___ Mixed Drinks
How many drinks per day do you have? _____ How many years have you drank alcohol? _____
How many caffeinated drinks do you have per day? _____
Do you have any pets? ___ Yes ___ No If yes what kind? _____
To what countries have you traveled out side of the United States?

_____

Birth History

Children under 18 years old

Did mother take prenatal vitamins? ___ Yes ___ No Birth weight _____Birth Height_____
Number days spent in the hospital?_____Full Term_____ Preterm _____Post term_____
Type of delivery? ___ Vaginal ___ C-section ___ Forceps ____ Vacuum
Maternal complications? ___ Yes ___ No (Pre-exclamsia, Exclampsis, Abruption, Maternal Diabetes)
Is child in daycare? ___ Yes ___ No ___ Full time ___ Part time Where?_____
Is your child in school? ____Yes ____No What grade?_____ Repeated a grade?____Yes _____No Which?_____
Special Ed? ____Yes ____No Which school does your child attend?_____

Name:_____

Family Medical History

Please list all <u>first-degree</u> relatives with the following illnesses:

Heart Attack: _____ **Stroke:** _____
Diabetes: _____ **High Blood Pressure:** _____
Cancer: _____ **Sudden Death:** _____
Mental Illness:_____
Drug/Alcohol:_____

Female History

Last menstrual period: _____**Do your periods come every month?** ___ **Yes** ___ **No If no how often?** _____
Is you flow ___ **heavy** ___ **light** ___ **medium?** **Do you get menstrual cramps?** ___ **Yes** ___ **No**
How long does your period last? _____
Do you have pain or bleeding after sexual intercourse? ___ **Yes** ___ **No**
How many times have you been pregnant? _____ **How many miscarriages or abortions have you had?** _____
How many times have you given birth? _____ **How many children do you have?** _____
What is your method of birth control? _____
Date of your last pap smear: _____**Have you ever had an abnormal pap?** ___ **Yes** ___ **No**
Do you get hot flashes? ___ **Yes** ___ **No** **Do you do self breast examinations?** ___ **Yes** ___ **No**
When was your last mammogram/breast exam? _____**Was it normal** ___ **Yes** ___ **No**

Review of Systems

Please check if you have or had any of the following in the <u>past six months:</u>

___ **Weight loss/gain**
___ **Night Sweats**
___ **Weakness**
___ **Rashes**
___ **Itching**
___ **Dry skin**
___ **Headaches**
___ **Injuries**
___ **Blurred vision**
___ **Ringing in ears**
___ **Hearing loss**
___ **Ear pain**
___ **Runny nose**
___ **Nose Bleed**
___ **Stuffy nose**
___ **Tooth pain**
___ **Dentures**
___ **Mouth sores**
___ **Sore throat**
___ **Hoarseness**
___ **Neck masses**
___ **Neck stiffness**
___ **Hair loss/growth**

___ **Chest pain**
___ **Racing heart**
___ **Difficulty breathing**
___ **Cough**
___ **Coughing up blood**
___ **Productive cough**
___ **Inability to lay flat**
___ **Breast pain**
___ **Nipple discharge**
___ **Mass in breast**
___ **Loss/increased appetite**
___ **Nausea**
___ **Vomiting**
___ **Diarrhea**
___ **Constipation**
___ **Indigestion**
___ **Vomiting blood**
___ **Black stools**
___ **Blood from rectum**
___ **Changes in bowel habits**
___ **Cold intolerance**
___ **Impotence**
___ **Decreased libido**

___ **Penile pain**
___ **Vaginal discharge**
___ **Irregular bleeding**
___ **Fatigue**
___ **Easy bruising**
___ **Bleeding**
___ **Pain in joints**
___ **Pain in muscles**
___ **Memory problems**
___ **Tingling in extremities**
___ **Numbness**
___ **One-sided weakness**
___ **Seizures**
___ **Anxiety**
___ **Depression**
___ **Heat intolerance**
___ **Urinary Tract Infection**

___ **Other pain (describe)**
_____
_____
_____

Patient/Guardian Signature_____ **Date:**_____

Received by: _____ **Date:** _____