FAMILY MEDICINE
New Patient Medical History Form

Personal History:

Name: _____ Date of Birth___/___/_____(mm/dd/yyyy)
Age_____Occupation _____
Birthplace_____(City&Country)
Marital Status (check one):
___Single___Married___Divorced___ Separated___ Widowed

MAIN PROBLEMS/REASONS FOR THIS VISIT:(if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____

***Note: we may not be able to address every problem during this visit.**

Current Medications	Dose/Strength	Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins/Supplements	Dose/Strength	Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: Medicines, Foods, Pollens, Pets etc… (Please list allergy with reaction.)

Allergy - Reaction	Allergy - Reaction
_____ - _____	_____ - _____
_____ - _____	_____ - _____
_____ - _____	_____ - _____
_____ - _____	_____ - _____

PREVIOUS HEALTHCARE PROVIDERS/DOCTOR

1._____
2._____
3._____

OVERALL HEALTH HISTORY REVIEW: Please circle all conditions that apply.

GENERAL	***EARS/NOSE/THROAT***	***EYES***
Fever	Hearing impairment	Vision changes
Fatigue	Ringing in ears	Vision loss
Chills	Sinus Infections	Glaucoma
Weakness	Neck pain	Cataracts
Dizziness	Difficulty swallowing	Eye injuries
Fainting	Hoarseness/Voice Changes	Contacts/Glasses
Abnl Weight Loss/Gain	Allergies	
Sleeping Problems	Nosebleeds	

SKIN	***PSYCHIATRIC***	***RESPIRATORY***
Easy bruising	Depression	Asthma
Dry skin	Anxiety	Pneumonia
Rash	Memory Loss	Emphysema
Acne		Breathing Problems

URINARY SYSTEM	***CARDIOVASCULAR SYSTEM***	***DIGESTIVE SYSTEM***
Frequent urination	Heart Attack	Abdominal Pain
Difficulty urinating	Chest Pains	Diarrhea
Pain when voiding	High blood pressure	Constipation
Blood in urine	Irregular Heartbeat	Hemorrhoids
Kidney stones	Heart Murmur	Ulcer
	High Cholesterol	Heartburn

NEUROLOGICAL

Seizure	Stroke	Numbness/Tingling
Weakness	Memory Loss	Headaches/Migraines

Have you ever been exposed to any of the following? (Please circle all that apply)

HIV - AIDS - Hepatitis - Sexually Transmitted Diseases

Please list any medical problems not shown above:

_____
_____

SURGICAL HISTORY:

Surgery	**Date**	**Location**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Tobacco Usage: (check one and fill in the blanks if indicated)

____Currently Smoking ____Former Smoker ____Never Smoked _____Frequent passive exposure

If Yes: Year started:_____How many cigarettes per day? _____

Year Started_____ Year Quit_____

Have you used smokeless tobacco: _____No _____Yes _____Former

If yes: Year started:_____ Year stopped:_____

Alcohol Intake: (check one and fill in the blanks if indicated)

_____No _____Yes _____Occasionally _____ drinks per day / week / month

Caffeine Intake:
_____No _____Yes _____Drinks/day Types of drinks:_____

Illicit Drug Use:
_____No _____Yes If yes, what types of drugs?_____

Exercise Type(s): _____ Times per week:_____

Sexually active? _____No_____Yes With whom? _____Men _____Women _____Both

Sun exposure: ____Frequently ____Occasionally ____Rarely

HEALTH SCREENING HISTORY: List the date of your most recent test or exam.

Breast Exam by Doctor_____ Prostate Exam_____ Testicle Exam by Doctor_____

Colonoscopy_____ Stress Test _____

Immunizations: Please list the date if known.

Tetanus_____ Flu Shot_____ Pneumonia_____

Hep B_____ MMR_____ PPD_____

FEMALE PATIENTS ONLY:

Date of last period:_____ Age of onset:_____ Duration of flow(days):_____

Number of days between each cycle_____ Flow: ___Light ___Med ___Heavy ___Exessive

Are you currently on birth control? _____No _____Yes What type?_____

Have you had a hysterectomy? _____No _____Yes Date of hysterectomy_____

Are you experiencing perimenopausal symptoms? ____No ____Yes Date of onset_____

Do you have menopausal symptoms? _____No _____Yes Age of menopause_____

Date of last Pap Smear _____ Have you ever had an abnormal Pap Smear? _____No_____Yes

Date of last Mammogram_____ Have you ever had an abnormal Mammogram? _____No_____Yes

Pregnancy History:

_____# Pregnancies _____# Live Births ____#Miscarriages ____#Abortions

_____# Vaginal deliveries _____# C-section _____#Premature _____#Ectopic

FAMILY HISTORY: Blood relatives only ___ (Check if adopted or no family history is known)

Please check all that apply	Father	Mother	Grandfather Maternal / Paternal		Grandmother Maternal / Paternal		Sister	Brother
Hearing Loss								
Vision Loss								
Blood Disorder								
Asthma								
Gout								
GI disorder								
Diabetes								
Heart Disease								
Heart Attack								
Congestive Heart Failure								
High Cholesterol								
High Blood Pressure								
Thyroid Problems								
Osteoporosis								
Arthritis								
Rheumatoid Arthritis								
Kidney Disease								
Liver Disease								
Migraines								
Seizure								
Stroke								
Dementia								
Depression								
Panic Attacks								
Anxiety								
Psychiatric Disorder								
Drug Abuse								
Alcohol Abuse								
Cancer								
If yes, type of Cancer								

Patient Signature_____ **Date**_____/_____/_____