

New Patient Medical History Information

Name:	Date:						
Medical History (4)							
If you are being referred to this office by another doctor, please name of the referring physician and his or her address:	e list the	HPI (4 Elem Location Quality Severity Mod factors	Use Only ents Needed) Duration Timing Context Signs/Symp				
If you are a self-referred patient, please list the doctors to who	m you would	like your wo	k-up sent:				
Major reason for coming to the doctor:							
Has a diagnosis for this problem been established? ☐ Yes ☐ If yes, what is the diagnosis and how was it established?] No						
How long have you had this problem?							
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What laboratory testing, including x-rays, h	nave you had?					
What treatment have you had for this problem?						
what treatment have you had for this problem?						
Which physicians have treated you in the ր	past for this problem?					
	Medications					
List all medications that you are taking (prescription or over the counter):						
List all medications that you are taking (pre	escription or over the counter)	:				
List all medications that you are taking (pre	escription or over the counter) <u>Dose</u>	: <u>Frequency</u>				
Medication						

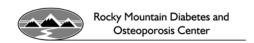
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Past Medical History						
List any surgeries that you have had:						
List serious illnesses that you have had:						
List serious injuries:						
Social	I History ⁽¹⁾					
Marital status: □married □single □widowed	□divorced	Number of Children:				
Occupation:	Religious preference:					
Do you drink? □Yes □No If yes, do you have more than 14 drinks per week? □Yes □No						
Have you ever smoked? □Yes □No How many years? Do you smoke now? □Yes □No How many packs a day?						
Family History ⁽¹⁾						
List family members with any of the following:						
Diabetes: Type 1	Cancer:					
Type 1 Type 2	Cancer.					
Stroke:	Thyroid disease:	:				
Coronary Artery disease (heart attacks, bypass surgery, angioplasty/stenting):						

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Health Maintenance							
Are you up to date on the following:							
□Yes □No Pap smear (women only) □Yes □No Mammogram (women only, yearly after age 50) □Yes □No Colonoscopy (colon cancer, every 5-10 years after age 50) □Yes □No Hemocoult: Test for blood in stool (colon cancer, yearly after age 50) □Yes □No Prostate Cancer blood test (PSA, men only) □Yes □No Bone density study (women and men) Year?							
Have you had the pneumonia vaccine (Pneumovac)? □Yes □No							
Date of your last dilated eye exam:							
	Pleas	se check (☑) any pro	bblems you may be havin	g:			
General: ☐ Fever ☐ Chills ☐ Weight Loss ☐ Weight Gain ☐ Fatigue ☐ Headache		Chest Pain Shortness of Breath Heart Racing Heart Pounding Ankle Swelling	Kidneys:☐ Burning with Urination☐ Loss of Urine☐ Blood in Urine☐ Difficulty with UrineFlow				
Eyes: ☐ Blurred Vision ☐ Floaters ☐ Infection ☐ Redness ☐ Pain in Eyes		Night (sleep apnea)	Musculoskeletal: ☐ Joint Pain ☐ Muscle Pain ☐ Back Pain ☐ Thin Bones ☐ Bone Fractures				
Ears/Nose/Throat: ☐ Earache ☐ Hearing Loss ☐ Sinus Infection ☐ Sores in Mouth ☐ Sore Throat		wels: Heartburn Acid Indigestion Nausea Vomiting Diarrhea	Neurologic: □ Numbness/Tingling		lergies:		
		Constipation Blood in Stools Trouble swallowing Black stools	Psychiatric: ☐ Anxiety ☐ Depression		medication		
Do you have any skin lesions that you are worried may be cancerous or pre-cancerous? □Yes □No Other problems to discuss with the doctor: 1							

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