New Patient Medical History

Patient's Name: _____ Date of Visit: _____

DOB: _____ Age: _____ Height: _____

Use a separate sheet of paper if you need more space

- **Medical History** – List all medical conditions you have had (including high blood pressure, diabetes, thyroid disease, heart disease, blood transfusions, etc.) and the dates of diagnosis:

_____

_____

_____

_____

- **Surgical History** – List all operations you have had and the dates of the surgeries:

_____

_____

_____

- **Other physicians / specialists you see**

_____

_____

_____

- **OB/GYN History** – This section for women only

Age at first menstrual period: _____ Date of 1st day of last period: _____

Number of pregnancies: _____ Live births: _____ Stillborn: _____

Miscarriage: _____ Abortion: _____

Have you had a hysterectomy? _____ If so, when? _____ Ovaries removed? _____

- **Health Maintenance** – Level of Activity/Exercise: _____

Dates of last test – Blood in stool: _____ Colonoscopy: _____ EKG: _____

Tetanus vaccine: _____ Flu Shot: _____ Pneumonia vaccine: _____

Zostavax: _____

Men only – PSA Test: _____ / **Women only** – Pap Smear: _____

Bone density: _____ Breast exam: _____ Mammogram: _____

- **Medications** – List all medications you take on a regular basis, including over-the-counter medicines, vitamins, and herbal supplements:

_____

_____

_____

_____

- **Allergies** – to medications or foods and reaction: _____

_____

- **Social History** – Marital status: _____ Occupation: _____

Alcohol: (how much, how often?) _____

Tobacco: (how much, how often?) _____

Illicit drug use: _____

- **Family History** – Please include any history of medical or psychiatric condition in your blood relatives including heart disease, stroke, diabetes, cancer, osteoporosis, depression, etc.

Relative	Age (current/at death)	Medical Illnesses
Mother	_____	_____
Father	_____	_____
Sibling	_____	_____
Grandparents	_____	_____
_____	_____	_____

Review of Systems

Constitutional	Yes/No	Comments
Fever		
Chills		
Night Sweats		
Unintentional weight gain		
Unintentional weight loss		
Excessive fatigue		
Eyes	**Yes/No**	**Comments**
Dryness		
Redness		
Change in vision		
Ear/Nose/Throat/Mouth	**Yes/No**	**Comments**
Hearing Loss		
Ringing in ears		
Nose bleeds		
Chronic sinus congestion		
Heavy snoring		
Change in voice		
Respiratory	**Yes/No**	**Comments**
Cough		
Phlegm/sputum production		
Sneezing		
Shortness of breath		
Cardiovascular	**Yes/No**	**Comments**
Chest discomfort or pressure		
Palpitations		
Leg Swelling		
Calf or buttock pain with walking		
Gastrointestinal	**Yes/No**	**Comments**
Change in appetite		
Difficulty swallowing		
Nausea/Vomiting		
Heartburn/indigestion		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool/black stool		
Genitourinary	**Yes/No**	**Comments**
Urination at night		
Frequent urination		
Burning with urination		
Blood in urine		
Incomplete emptying		
Leakage of urine		
Sexual problems		

Women	Yes/No	Comments
Vaginal discharge		
Abnormal vaginal bleeding		
Pelvic pain		
Breast lumps		
Nipple discharge		
Musculoskeletal	**Yes/No**	**Comments**
Persistent or severe neck pain		
Persistent or severe back pain		
Persistent or severe joint pain		
Muscle pain or cramping		
Skin	**Yes/No**	**Comments**
Rash		
Itching		
Growths/lesions		
New or changing moles		
Acne		
Neurologic	**Yes/No**	**Comments**
Frequent or severe headaches		
Falls		
Numbness/tingling		
Tremor		
Involuntary movement		
Muscle weakness		
Memory loss		
Dizziness		
Psychosocial	**Yes/No**	**Comments**
Anxiety/nervousness		
Panic		
Feeling sad or depressed		
Insomnia		
Endocrine	**Yes/No**	**Comments**
Cold/heat intolerance		
Hot flashes		
Excessive thirst		
Blood/Lymphatics	**Yes/No**	**Comments**
Excessive bruising		
Easy bleeding		
Swollen lymph nodes		
Allergy/Immunity	**Yes/No**	**Comments**
Severe allergic reactions		
Hives		
Frequent infections		