Family Medicine Clinic
New Patient History Form

Name:_____ Date of Birth:_____ M F

Race: _____ Ethnicity: _____ Preferred Language: English Spanish Other

Email Address: _____

Medical History: (check all that apply)

- ❑ Allergies
- ❑ Angina
- ❑ Alcoholism/ Drug abuse
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Back problems
- ❑ Blood in stool
- ❑ BPH
- ❑ Constipation
- ❑ Dental problems
- ❑ COPD/ Emphysema
- ❑ Cancer
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Depression
- ❑ Diabetes Mellitus
- ❑ Dizzy spells
- ❑ Difficulty swallowing
- ❑ Diverticulosis
- ❑ Crohn's disease/ Ulcerative colitis
- ❑ Eye problems
- ❑ Gallbladder disease
- ❑ Gout
- ❑ Headaches
- ❑ Hearing problems
- ❑ Heart attack
- ❑ Heartburn
- ❑ Heart failure
- ❑ Hepatitis
- ❑ Heart murmur
- ❑ Fainting spells
- ❑ Hernia
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heartbeat
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Menopause
- ❑ Menstrual irregularities
- ❑ Migraines
- ❑ Osteoporosis/ Osteopenia
- ❑ Pancreas disease
- ❑ Peripheral vascular disease
- ❑ Prostate infection
- ❑ Psoriasis
- ❑ Recurrent sinusitis
- ❑ Sexually transmitted infection
- ❑ Sleeping difficulties
- ❑ Thyroid disease
- ❑ Ulcers
- ❑ Recurrent urinary tract infections
- ❑ Seizures
- ❑ Other

Have you ever had any operations? If so, what, when, why:

_____
_____
_____
_____
_____

List all medications you are taking (including vitamins)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies

_____
_____
_____
_____
_____
_____
_____

Vaccine History

Tetanus _____
Flu _____
Pneumonia _____
Shingles _____
Tuberculosis screening _____

Occupation: _____
How many times per week do you exercise? _____
Do you use tobacco products? N Y if so, how much: _____
Do you drink alcohol? N Y if so, how much: _____
Do you use illegal drugs? N Y if so, what, how much, how often: _____

Do you have any other specialist doctors or health care providers?
Please list them as well as conditions they are treating

_____
_____

Family Medical History: List who has or has had the following; i.e. Mom, Dad, Sibling, Paternal or Maternal Grandmother/ Grandfather

Cancer (Type) _____
Diabetes _____
High Blood Pressure _____
Heart Disease _____
High Cholesterol _____
Stroke _____
Alzheimer's _____
Osteoporosis _____
Alcohol/ Drug Abuse _____
Other _____

Females Only:
Any problems with urination? N Y if so, what: _____
Menstrual flow Regular Irregular Pain/ Cramps
1st day of last period: _____
Number of: Pregnancies _____ Children _____ Abortions _____ Miscarriages _____
Birth Control Method _____
Last Mammogram _____ Last Pap Smear _____

Males Only:
Any urination or prostate problems? N Y if so, what: _____
Last PSA/ Prostate exam _____
Any problems with your libido? _____
Have you had a vasectomy? N Y