

# New Patient Medical History Form

(For All Patients 18yrs and older)

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please list all of your current medications and associated dosage and frequency/instructions:**

(Be sure to include any "over-the-counter" medications, supplements, vitamins, etc.)

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

**List all of the allergies that you have (medications, foods, environment, etc.) and associated reaction:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Medical History: (Please circle any condition that applies to you)**

- |             |                     |                      |                  |
|-------------|---------------------|----------------------|------------------|
| Cancer      | Heart Attack        | High Blood Pressure  | High Cholesterol |
| Diabetes    | Joint Pain          | History of Fractures | Blood Clots      |
| Asthma      | Shortness of breath | Migraine Headaches   | Depression       |
| Skin issues | Eye Disease         | Hearing Issues       |                  |

Other: \_\_\_\_\_

**Surgical History:** \_\_\_\_\_

\_\_\_\_\_

**When was your last:** Tetanus Shot/ Tdap/Adacel \_\_\_\_\_ TB Test (PPD) \_\_\_\_\_ Colonoscopy \_\_\_\_\_

Pneumonia Shot \_\_\_\_\_ Hepatitis B Vaccine \_\_\_\_\_ Physical Exam \_\_\_\_\_

**Female Patients ONLY: (Please skip this section if the questions do not apply to you)**

Number of total pregnancies? \_\_\_\_\_ Number of Births? \_\_\_\_\_ Date of Last Mammogram: \_\_\_\_\_  
Date of last menstrual period: \_\_\_\_\_ Date of last bone density scan: \_\_\_\_\_  
Date of last pap smear: \_\_\_\_\_ Are you using birth control (oral, injection, IUD, etc.) currently? \_\_\_\_\_

**Do you have a Health Care Proxy?**      No      Yes

**Do you smoke?**      No      Yes:    How often: \_\_\_\_\_

**Do you drink alcohol?**      No      Yes:    Number of times per week: \_\_\_\_\_

**Your Family's Medical History: (Circle any condition that your blood relatives have)**

- |             |                     |                      |                  |
|-------------|---------------------|----------------------|------------------|
| Cancer      | Heart Attack        | High Blood Pressure  | High Cholesterol |
| Diabetes    | Joint Pain          | History of Fractures | Blood Clots      |
| Asthma      | Shortness of breath | Migraine Headaches   | Depression       |
| Skin issues | Eye Disease         | Hearing Issues       |                  |

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please list any questions or concerns that you have below:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**How did you hear about FMMC?** \_\_\_\_\_

**FMMC Provider Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_