NEW PATIENT

MEDICAL HISTORY FORM

(Skip any section that is not applicable)

**Please return to our office in person, via mail, via fax or email at** **sdrake@gfppc.com**

**Please use black pen only**

FULL NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES **NO ALLERGIES**

|  |  |
| --- | --- |
| **ALLERGY** | **ALLERGIC REACTION** |
|  |  |
|  |  |
|  |  |

MEDICATIONS **(LIST ONLY IF DIFFERENT FROM NEW PATIENT QUESTIONNAIRE)**

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | **DOSE** | **TIMES PER DAY** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

If you need more room to list medications, please write them on the back of this paper.

HEALTH MAINTENANCE SCREENING TEST HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| **CHOLESTEROL** | **DATE:** | **FACILITY/PROVIDER:** | **ABNORMAL RESULT? Y N** |
| **COLONOSCOPY/SIGMOID** | **DATE:** | **FACILITY/PROVIDER:** | **ABNORMAL RESULT? Y N** |
| **MAMMOGRAM** | **DATE:** | **FACILITY/PROVIDER:** | **ABNORMAL RESULT? Y N** |
| **PAP SMEAR** | **DATE:** | **FACILITY/PROVIDER:** | **ABNORMAL RESULT? Y N** |
| **BONE DENSITY** | **DATE:** | **FACILITY/PROVIDER:** | **ABNORMAL RESULT? Y N** |
| **GLUCOSE** | **DATE:** | **FACILITY/PROVIDER:** | **ABNORMAL RESULT? Y N** |
| **IF DIABETIC: LAST A1C:** | **DATE:** | **FACILITY/PROVIDER:** | **ABNORMAL RESULT? Y N** |

VACCINATION HISTORY**(Please provide copy of immunization record if pediatric patient)**

|  |  |
| --- | --- |
| Last Tetanus Booster or TdaP: | Last Pneumovax (Pneumonia) |
| Last Flu Vaccine: | Last Prevnar: |
| Last Zoster Vaccine (Shingles): |  |

PERSONAL MEDICAL HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| **DISEASE/CONDITION** | **CURRENT** | **PAST** | **COMMENTS** |
| ALCOHOLISM/DRUG ABUSE |  |  |  |
| ASTHMA |  |  |  |
| CANCER (TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |  |  |
| DEPRESSION/ANXIETY/BIPOLAR |  |  |  |
| DIABETES (TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |  |  |
| EMPHYSEMA (COPD) |  |  |  |
| HEART DISEASE |  |  |  |
| HIGH BLOOD PRESSURE |  |  |  |
| HIGH CHOLESTEROL |  |  |  |
| HYPOTHYROIDISM/THYROID DISEASE |  |  |  |
| RENAL (KIDNEY) DISEASE |  |  |  |
| MIGRAINE HEADACHES |  |  |  |
| STROKE |  |  |  |
| OTHER: |  |  |  |

SURGERIES

|  |  |  |
| --- | --- | --- |
| **TYPE (SPECIFY LEFT/RIGHT)** | **DATE** | **SURGEON** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

FAMILY MEDICAL HISTORY NO SIGNIFICANT FAMILY HISTORY IS KNOWN

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **√ CHECK ALL THAT APPLY** | ALCOHOL/DRUG ABUSE | ASTHMA | CANCER (TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | EMPHYSEMA (COPD) | DEPRESSION/ANXIETY | BIPOLAR | DIABETES | EARLY DEATH | HEART DISEASE | HIGH CHOLESTEROL | HIGH BLOOD PRESSURE | KIDNEY DISEASE | STROKE | THYROID DISEASE | MIGRAINES | OTHER: \_\_\_\_\_\_\_\_\_\_\_\_ | OTHER\_\_\_\_\_\_\_\_\_\_\_\_ |
| MOTHER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| FATHER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| BROTHER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SISTER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CHILD DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL GRANDMOTHER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MATERNAL GRANDFATHER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL GRANDMOTHER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PATERNAL GRANDFATHER DECEASED Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| OTHER:\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

SOCIAL HISTORY

|  |  |
| --- | --- |
| OCCUPATION (OR PRIOR OCCUPATION): |  RETIRED UNEMPLOYED LOA DISABLED |
| EMPLOYER: | YEARS OF EDUCATION OR HIGHEST DEGREE: |
| MARITAL STATUS: SINGLE PARTNER MARRIED DIVORCED OTHER: \_\_\_\_\_\_\_\_\_\_\_\_ |
| DO YOU HAVE CHILDREN? Y N | IF YES, HOW MANY? |

OTHER HEALTH ISSUES

|  |  |
| --- | --- |
| **TOBACCO USE** | SMOKE CIGARETTES? Y N (IF YOU NEVER SMOKED, PLEASE MOVE TO ALCOHOL/DRUG USE) |
| CURRENT: PACKS/DAY \_\_\_\_\_ # OF YEARS | PAST: QUIT DATE: \_\_\_\_\_\_\_\_\_\_ PACKS/DAY\_\_\_\_\_\_ # OF YEARS \_\_\_\_\_\_\_ |
| OTHER TOBACCO (CHECK ONE) PIPE CIGAR SNUFF CHEW VAPE |
| **ALCOHOL/DRUG USE** | DO YOU DRINK ALCOHOL? Y N | # OF DRINKS PER WEEK: \_\_\_\_\_\_\_\_ |
| DO YOU USE MARIJUANA OR RECREATIONAL DRUGS? Y N  |
| WORKING SMOKE DETECTORS IN HOME? Y N  |
| HAVE YOU COMPLETED AN ADVANCE DIRECTIVE FOR HEALTH CARE, LIVING WILL, OR PHYSICAL ORDERS FOR LIFE SUSTAINING THERAPY (POLST)? Y N |

OTHER PROVIDERS/SPECIALISTS

|  |  |  |
| --- | --- | --- |
| **SPECIALIST** | **NAME** | **LAST VISIT** |
| CARDIOLOGY |  |  |
| GASTROENTEROLOGIST (GI) |  |  |
| OB/GYN |  |  |
| NEUROLOGY |  |  |
| PULMONARY |  |  |
| OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

REVIEW OF SYSTEMS √ CHECK ALL THAT APPLY

|  |  |  |
| --- | --- | --- |
| **CONSTITUTION** | **CARDIOVASCULAR** | **SKIN** |
|  | HAIR LOSS |  | CHEST PAIN |  | COLOR CHANGE |
|  | APPETITE CHANGE |  | LEG SWELLING |  | RASH |
|  | CHILLS |  | PALPATATIONS |  | WOUND |
|  | SWEATS | **GASTROINTESTINAL** | **ALLERGY/IMMUNO** |
|  | FATIGUE |  | ABDOMINAL DISTENTION |  | EVIRONMENTAL ALLERGIES |
|  | FEVER |  | ABDOMINAL PAIN |  | FOOD ALLERGIES |
|  | UNEXPECTED WEIGHT CHANGE |  | BLOOD IN STOOL |  | IMMUNOCOMPROMISED |
| **HEAD, EAR, NOSE & THROAT** |  | CONSTIPATION | **NEUROLOGICAL** |
|  | CONGESTION |  | DIARRHEA |  | DIZZINESS |
|  | DROOLING |  | NAUSEA |  | HEADACHES |
|  | EAR DISCHARGE |  | RECTAL PAIN |  | LIGHT-HEADEDNESS |
|  | EAR PAIN |  | VOMITING |  | NUMBNESS |
|  | FACIAL SWELLING | **ENDOCRINE** |  | SEIZURES |
|  | HEARING LOSS |  | COLD INTOLERANCE |  | SPEECH DIFFICULTY |
|  | NOSEBLEEDS |  | HEAT INTOLERANCE |  | PASSING OUT EPISODES |
|  | POSTNASAL DRIP |  | INCREASED THRIST |  | TREMORS |
|  | SINUS PRESSURE |  | EXCESSIVE HUNGER |  | WEAKNESS |
|  | SNEEZING |  | INCREASED URINATION | **HEMATOLOGIC** |
|  | SORE THROAT | **GENITOURINARY** |  | BRUISES/BLEEDS EASILY |
|  | RINGING IN THE EARS |  | DIFFICULTY URINATION | **PSYCHIATRIC** |
|  | TROUBLE SWALLOWING |  | PAIN WITH URINATION |  | BEHAVIOR PROBLEM |
| **EYES** |  | FLANK PAIN |  | CONFUSION |
|  | EYE DISCHARGE |  | FREQUENCY |  | DECRESAED CONCENTRATION |
|  | EYE ITCHING |  | BLOOD IN URINE |  | HALLUCINATIONS |
|  | EYE PAIN |  | URGENY |  | HYPERACTIVE |
|  | EYE REDNESS |  | DECREASED URINE OUTPUT |  | NERVOUS/ANXIOUS |
|  | VISUAL DISTURBANCE | **MUSCULAR** |  | SELF-INJURY |
| **REPIRATORY** |  | BACK PAIN |  | SLEEP DISTURBANCE |
|  | SLEEP APNEA |  | GAIT PROBLEMS |  | SUICIDIAL IDEAS |
|  | CHEST TIGHTNESS |  | JOINT PAIN |  |  |
|  | CHOKING |  | NECK PAIN |  |  |
|  | COUGH |  |  |  |  |
|  | SHORTNESS OF BREATH |  |  |  |  |
|  | WHEEZING |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |