HEALTH HISTORY UPDATE FOR NEW PATIENTS

Date: _____

Name: _____

Date of Birth: _____ Age: _____

This form will update your medical information. Please complete it and bring it your appointment. It should take about 10 minutes to fill out, and it may be easier if you have your calendar and medicines nearby. This information will help your doctor provide you with the most appropriate care. Thanks for completing this form.

Please indicate your main health concerns:

_____

MEDICATION ALLERGIES:

List all medications that you are allergic to or don't tolerate. Please describe the reaction (rash, swelling, nausea):

_____

_____

_____

CURRENT MEDICATIONS, VITAMINS, AND SUPPLEMENTS:

(Include prescriptions, over the counter, herbal, or dietary supplements) If you prefer to bring a list or your pill bottles to the visit that is fine. If you bring a list or the bottles you may skip this section.

MEDICATION	DOSE	TAKEN HOW OFTEN
For example:		
Calcium		
Multivitamin		

Vitamin D

Aspirin

Pain medications (Motrin, Advil, Aleve, Tyelnol)

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please check the symptoms you are currently experiencing or have recently experienced.

GENERAL:

Excessive sleepiness

Sleeplessness (insomnia)

Fever

Night sweats

Hot flashes

Weight gain

Weight loss

Loss of appetite

Fatigue

SKIN:

Rash

Dryness

Nail problems

Itching

Hair problems

New / changing moles

Bruises

Other skin conditions

HEAD-EYES-EARS-NOSE-THROAT:

Double vision/blurry vision

Diminished vision

Itchy eyes

Hearing loss/wearing hearing aides

Ear clogging

Ringing in ears

Jaw pain/TMJ

Sinus congestion/Stuffy nose

Nasal drip (runny nose)

Bloody nose

Hoarseness

Sore throat

NODES AND GLANDS:

Swollen/Painful glands

Excessive thirst

Cold intolerance

Heat intolerance

BREASTS:

Lumps or cysts

Breast pain prior to menstruations

Nipple discharge

LUNGS:

Shortness of breath

Cough

Coughing up blood

CARDIOVASCULAR:

Chest discomfort

Irregular pulse (skip beats)

Leg pain with walking

Swelling in feet or ankles

Dizziness or fainting spells

Decreased exercise tolerance

GASTROINTESTINAL:

Difficulty swallowing/pain with swallowing

Heartburn

Nausea

Vomiting

Abdominal pain

Diarrhea

Constipation

Hemorrhoids

Blood in stool

GENITO-URINARY:

Loss of bladder control (incontinence)

Blood in urine

Pain/Burning with urination

Awakening at night to urinate

MUSCULOSKELETAL:

Muscle weakness

Joint pain/swelling/stiffness

Difficulty walking due to joint or muscle pain

Leg cramps

NEUROLOGICAL/PSYCHIATRIC:

Memory loss

Loss of coordination

Numbness/tingling

Headache

Loss of balance

Anxiety

Depression

MEN ONLY:

Are you currently/recently sexually active?

Do you have any sexual concerns?

Who do you have sex with? Men _____ Women _____ Both _____

Decreased sex drive/low libido

Difficulty getting an erection or maintaining an erection

Difficulty starting to urinate

Feeling of incomplete bladder emptying

Decreased urinary stream

Discharge from penis

WOMEN ONLY:

Are you currently / recently sexually active?

Do you have any sexual concerns?

Who do you have sex with? Men _____ Women _____ Both _____

Pain with Intercourse?

Loss of sex drive/Other sexual difficulties?

Do you use any type of Birth Control? What type?

If you still get your period:

Date last normal menstrual cycle began:

Are your Periods regular?

Do you get painful menstrual cramps?

How long does your period last?

Do you get spotting between Periods?

Have you tried to get pregnant unsuccessfully?

Have you sought care for infertility?

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Have you gone through menopause? _____ Age at Menopause? _____

SOCIAL HISTORY

Do you drink beverages containing caffeine? _____

If so, what do you drink and how often? _____

Do you smoke? _____

Do you vape? _____

Do you drink alcohol? _____

Do you use recreational drugs? _____

Do you use any medication prescribed for another person? _____

What do you do for exercise? _____

Describe your diet: _____

If you are working, what sort of work do you do? _____

Do you have guns in the home? _____

What are your hobbies/interests? _____

PREVENTION

Vaccinations (if given to you by another provider)	Date Given
Tetanus (every 10 years)	_____
Pertussis/Tetanus (Tdap/Adacel)	_____
Pneumonia (there are now two)	
• Pnenumovax	_____
• Prevnar 13	_____
Shingles	
• Shingrix (2 shots)	_____
• Zostavax	_____
Colonoscopy (over 50, sooner if family history)	

<u>Women only</u>

Who is your GYN?

Papsmear/gyn exam

Bone density test (dexa; for postmenopausal)

Mammogram

Where else have you gone for medical care in the past year?

For Example:

ER (emergency room) Urgent Care

Cardiologist

Dermatologist

Eye doctor (ophthalmologist)

Gynecologist

Neurologist

Orthopedist

Urologist

Others:

_____

_____

_____

_____

_____

_____

Please list any surgeries you have had (even surgeries done years ago):

Date: _____ Type of surgery: _____

_____

_____

_____

_____

In the past or currently do you have any of the following health conditions?

Cancer

Anemia

Difficulty clotting

Sickle Cell Anemia

Thalassemia

Overactive Thyroid (hyperthyroidism)

Underactive Thyroid (hypothyroidism)

Asthma

Emphysema/COPD

High blood pressure (hypertension)

Fainting spells (syncope)

Heart murmur

Heart rhythm problem (ex: atrial fibrillation)

Heart valve problem

Coronary Artery Disease/Heart Attack

Varicose veins

Hiatal hernia

Ulcer

Colitis

Gallbladder disease

Hepatitis

Bladder or kidney infections (UTI)

Kidney stones

Gout

Arthritis

Seizures

In addition to anything noted above please list any acute or chronic medical problems that interfere with your daily life.

Year of Onset	Illness/Condition	Treatments

FAMILY HISTORY: Please note major health problems of your parents, grandparents, siblings, and children. Please indicate which member of your family has or had the condition.

For example:

Diabetes

Cancer

High blood pressure

High cholesterol

Heart attack

Stroke

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS MEDICAL FORM. PLEASE REMEMBER TO BRING THIS FORM WITH YOU TO YOUR VISIT.