BREEN
FAMILY MEDICINE

NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Date of birth: _____ Age: _____

How did you find us/referred by anyone: _____

ALLERGIES

▫ No allergies

ALLERGY	Allergic Reaction

MEDICATIONS

MEDICATIONS (PLEASE LIST ALL)	DOSE	TIMES PER DAY

(If you take additional medications please add to back of paper)

HEALTH MAINTENCE SCREEING TEST HISTORY

COLONOSCOPY	Date:	Abnormal results? Y N	Family Hx colon cancer:
MAMMOGRAM	Date:	Abnormal results? Y N	Family Hx breast cancer:
PAP SMEAR	Date:	Abnormal results? Y N	Family Hx cervical cancer:
BONE DENSITY	Date:	Abnormal results? Y N	Family Hx osteoporosis:

VACCINE HISTORY

Td or Tdap	Date:
Influenza	Date:
Prevnar (PCV 13)	Date:
Pneumovax (PPSV 23)	Date:
Shingrix (shingles)	Date:
Hepatitis B	Date:

SURGICAL HISTORY

Type *(specify left/right)*	**Date**

SOCIAL HISTORY

Occupation:	▫ Retired ▫ Unemployed ▫ LOA ▫ Disabled
Employer:	Years of Education or highest degree:
Marital status: ▫ Single ▫ Partner ▫Married ▫Divorced ▫Widowed ▫Other:	
Do you have children: Y N	If so, how many:

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug abuse			
Asthma			
Cancer *(type)*: _____			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes			
COPD			
High blood pressure			
High cholesterol			
Thyroid disease			
Kidney disease			
Stroke			

WOMEN'S HEALTH HISTORY

Date of last menstrual cycle:	Age of first menstruation: Age of menopause:
Total number of pregnancies:	Number of live births:
Pregnancy complications:	

OTHER HEALTH ISSUES

TOBACCO USE	Current smoker? Y N Former smoker? Y N Currently vaping? Y N		
Current: Packs/day _____ # of years: _____	**Past**: Quit date: _____ Packs/day:_____ # of years:_____		
Other tobacco use: ▢ pipe ▢ cigar ▢ Snuff ▢chew			
ALCOHOL/DRUG USE	Do you drink alcohol: Y N	▢ beer ▢wine ▢liquor	# drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

SEXUAL ACTIVITY	Sexually involved currently? Y N (if no sexual history, skip to Exercise)
Sexual partner(s) is/are/have been: ▢ Male ▢ Female	
Birth control method: ▢ None ▢ Condoms ▢ Pill/Ring/Patch/Inj/IUD ▢Vasectomy ▢ Tubal	
EXERCISE	Do you exercise regularly? Y N (if you answered no, please skip to Sleep)
What kind of exercise	Duration: How long (min): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night (or during the day, if working night shift):
DIET	How would you rate your diet? ▢ Good ▢ Fair ▢ Poor
SAFETY	Do you wear the following: Bike helmet Y N, Seat Belt Y N
Working smoke detectors in home? Y N, If you have guns at home, are they locked up? Y N	

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurologist		
Nephrologist (kidney)		
Ophthalmologist (eye)		

REVIEW OF SYSTEMS

CONSTITUTION	CARDIOVASCULAR	SKIN
☐ Activity changes	☐ Chest pain	☐ Color changes
☐ Appetite changes	☐ Leg swelling	☐ Abnormal moles
☐ Chills	☐ Palpitations	☐ Rash
☐ Excessive sweating	**GASTROINTESTINAL**	☐ Wound
☐ Fatigue	☐ Abdominal distention	**ALLERGY/IMMUNO**
☐ Unexpected weight loss	☐ Abdominal pain	☐ Environmental allergies
HEAD, EAR, NOSE & THROAT	☐ Rectal pain	☐ Food allergies
☐ Sinus congestion	☐ Blood in stool	☐ Immunocompromised
☐ Dental problems	☐ Constipation	**NEUROLOGIC**
☐ Ear pain/discharge	☐ Diarrhea	☐ Dizziness
☐ Facial swelling	☐ Nausea	☐ Facial asymmetry
☐ Hearing loss	☐ Vomiting	☐ Headaches
☐ Mouth sores	☐ Acid reflux/heart burn	☐ Numbness
☐ Nose bleeds	**ENDOCRINE**	☐ Seizures
☐ Postnasal drainage	☐ Cold intolerance	☐ Speech difficulty
☐ Sore throat	☐ Heat intolerance	☐ Passing out (syncope)
☐ Ringing in ears (tinnitus)	☐ Increased thirst (polydipsia)	☐ Tremors
☐ Trouble swallowing	☐ Increased hunger (polyphagia)	☐ Weakness
☐ Sneezing	☐ Increased urination (polyuria)	**MEN'S HEALTH**
EYES	**GENITOURINARY**	☐ Erectile dysfunction
☐ Eye discharge	☐ Difficulty urinating	☐ Loss of libido
☐ Eye itching	☐ Pain with urination	**PSYCIATRIC**
☐ Eye pain	☐ Bed wetting	☐ Irritability
☐ Sensitivity to light	☐ Flank pain	☐ Confusion
☐ Visual disturbances	☐ Frequency	☐ Anxiety
RESPIRATORY	☐ Genital sores	☐ Depression
☐ Apnea	☐ Blood in urine	☐ Insomnia
☐ Chest tightness	☐ Penile discharge/pain	☐ Self-injury
☐ Choking	☐ Scrotal swelling/pain	☐ Suicidal thoughts
☐ Cough	☐ Decreased urination	☐ Hyperactivity
☐ Asthma	**MUSCULAR**	☐ Decreased concentration
☐ Shortness of breath	☐ Joint pains	**GYNECOLOGIC**
☐ Wheezing	☐ Back pain	☐ Painful menses
HEMATOLOGIC	☐ Gait/balance problems	☐ Irregular menses
☐ Swollen lymph nodes	☐ Joint swelling	☐ Breast lumps/pain
☐ Bruises/bleeds easily	☐ Muscle aches	☐ Vaginal dryness
☐	☐ Neck pain	☐ Pain with intercourse

Family Medical History

☐ adopted

✓ CHECK ALL THAT APPLY	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Alcohol/Drug Abuse								
Asthma								
COPD								
Depression/Anxiety								
Diabetes								
High cholesterol								
High blood pressure								
Kidney disease								
Stroke								
Thyroid disease								

Cancer (specify type & family member): _____