**New Patient Medical History Form**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How did you find us/Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Allergies*** no allergies (seasonal, food, medications)

|  |  |
| --- | --- |
| Allergy | Allergic Reaction |
|  |  |
|  |  |
|  |  |

***Medications*** (All including over the counter & herbal meds)

|  |  |
| --- | --- |
|  |  |
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|  |  |
|  |  |
|  |  |

If you take additional medications, please attach another piece of paper)

***Vaccine History***

|  |  |
| --- | --- |
| DTap (2m, 4m, 6m, 15m, 5yo) | Dates: |
| Influenza (6m & 7m, yrly)(most resent) | Date: |
| Rotavirus (2m, 4m, 6m)  | Dates: |
| Hep A (12m, 18m) | Dates::: |
| Hep B (NB, 1-2m, 6m) | Dates: |
| HiB (2m, 4m, 6m, 12-15m) | Dates: |
| Covid-19 (Pfizer/Moderna) | Dates: |
| PCV 13 (2m, 4m, 6m, 12-15m) | Dates: |
| Polio IPV (2m, 4m, 6-18m, 5yo) | Dates: |
| MMR (12-15m, 5yo) | Dates:  |
| Varicella (12-18m & 5yo) |  |

***Surgical History***

|  |  |
| --- | --- |
| Type (Specify Left/Right) | Date |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

***Social History***

|  |  |
| --- | --- |
| Years of education: | Currently living with: |
| Marital Status of parents: Harvey Balls 0% with solid fillSingle Harvey Balls 0% with solid fillPartner Harvey Balls 0% with solid fillMarried Harvey Balls 0% with solid fillDivorced Harvey Balls 0% with solid fillWidowed Harvey Balls 0% with solid fillOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have siblings? Y N  | If Yes, how many?  | Patients @ BMFAC? Y N |
| Sexual Activity (if no sexual activity has ever been had, skip the next line) |
| Sexually involved currently: Y N | Sexual Preference: M F Other: \_\_\_\_\_\_ |
| Birth Control Method/STD Prevention:Harvey Balls 0% with solid fillNone Harvey Balls 0% with solid fillCondoms Harvey Balls 0% with solid fillPill/Ring/Patch/Inj./IUD Harvey Balls 0% with solid fill Vasectomy Harvey Balls 0% with solid fill Tubal |
| Tobacco Use (ever): Y N | Current Smoker? Y N | Former Smoker? Y N  | Current Vaping? Y N |
| Current: Packs/day use: \_\_\_\_\_\_\_\_\_\_ # Years: \_\_\_\_\_\_ | Past: Quit Date: \_\_\_\_\_\_ Packs/day: \_\_\_\_\_\_ #Yrs: \_\_\_\_ |
| Other Tobacco Use: Harvey Balls 0% with solid fillPipe Harvey Balls 0% with solid fillCigar Harvey Balls 0% with solid fill Snuff Harvey Balls 0% with solid fillChew  | Exposed to 2nd hand smoke? Y N |
| Alcohol Use: Y N | Beer Wine Liquor | #drink/weekly: \_\_\_\_\_\_\_\_ | Family Hx etoh abuse: Y N |
| Exposed to alcohol? Y N | Exposed to drugs? Y N |
| Drug Use: Y N | Marijuana Cocaine Meth Heroin Spice LSD MDMA Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you ever used needles to inject drugs? Y N | Have you ever taken someone else's drugs? Y N |
| Exercise Habits: Y N  | If Yes, type:  | How long: \_\_\_\_\_\_\_\_\_\_ | How Often: \_\_\_\_\_\_\_\_\_ |
| Sleep: On average/ out of 7 days how many hours of sleep do you get daily: |
| How would you rate the quality of your diet? Harvey Balls 0% with solid fillGood Harvey Balls 0% with solid fillFair Harvey Balls 0% with solid fillPoor |
| Meals per day (3 meals 2 snacks)?  | List foods eaten past 24 hrs: |
| Safety  | Do you wear the following: Harvey Balls 0% with solid fillBike Helmet Harvey Balls 0% with solid fillHelmets with sports (ex. Skiing) Harvey Balls 0% with solid fill Seat Belt |
| Smoke detectors working in home: Y N | Guns in the home: Y N | If Yes, locked up? Y N |
| Hobbies:  | Pets:  |

***Person Medical History***

|  |  |  |  |
| --- | --- | --- | --- |
| Disease/Condition | Current | Past  | Comments |
| Asthma |  |  |  |
| Cancer (*type*): |  |  |  |
| Depression/Anxiety/Bipolar/Suicidal |  |  |  |
| Diabetes (*type*):  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

***Women's Health History***

|  |  |
| --- | --- |
| Date of last menstrual cycle: | Age of first menstruation:: |
| Total number of pregnancies: | Birth Control: |
| Number of live births: | Pregnancy complications: |

***Other Providers/Specialists***

|  |  |
| --- | --- |
| Specialist | Name |
| Cardiology (heart) |  |
| Dermatologist (skin) |  |
| Gastroenterologist (GI) |  |
| Hematologist (Blood) |  |
| OB/GYN |  |
| Neurologist |  |
| Oncologist (cancer) |  |
| Ophthalmologist (eye) |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

***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 |  |  |  |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |

***Review of Systems*** (Mark all that apply)

|  |  |  |
| --- | --- | --- |
| Constitution | Cardiovascular | Skin |
|  | Activity Changes |  | Chest Pain |  | Color Changes |
|  | Appetite Changes |  | Leg Swelling |  | Rash |
|  |  Chills |  | Heart Palpitations |  | Wound |
|  | Fatigue | **Gastrointestinal** |  | Abnormal moles |
|  | Unexplained weight loss |  | Abdominal distention | **Allergy/Immuno.** |
| Head, Ear, Eyes, Nose, Throat |  | Abdominal pain |  | Environmental allergies |
|  | Sinus congestion |  | Rectal Pain |  | Food Allergies |
|  | Dental problems |  | Blood in stool |  | Immunocompromised |
|  | Ear pain/discharge |  | Constipation | **Neurological** |
|  | Facial swelling |  | Diarrhea |  | Dizziness |
|  | Hearing loss |  | Nausea |  | Facial asymmetry |
|  | Mouth sores |  | Acid reflux/heart burn |  | Headaches |
|  | Nose bleeds  | **Endocrine** |  | Seizures |
|  | Postnasal drainage |  | Cold intolerance |  | Speech difficulty  |
|  | Sore throat |  | Heat intolerance |  | Passing out (syncope) |
|  | Ringing in ears (tinnitus) |  | Increased thirst |  | Tremors |
|  | Trouble swallowing  |  | Increased hunger |  | Weakness |
|  | Sneezing |  | Increased urination | **Men's Health** |
|  | Eye discharge | **Genitourinary**  |  | Erectile dysfunction |
|  | Eye Itching  |  | Difficulty urinating |  | Loss of libido |
|  | Eye pain |  | Pain with urination | **Psychiatric** |
|  | Sensitivity to light |  | Bed wetting |  | Irritability  |
|  | Visual disturbances |  | Flank pain |  | Confusion |
| Respiratory  |  | Frequency  |  | Anxiety  |
|  | Apnea |  | Genital sores |  | depression |
|  | Chest tightness |  | Blood in urine |  | Insomnia |
|  | Choking |  | Penile discharge/pain |  | Self-injury |
|  | Cough |  | Decreased urination |  | Suicidal thoughts |
|  | Asthma  | **Muscular** |  | Hyperactivity |
|  | Shortness of breath |  | Joint pains |  | Decreased concentration |
|  | Wheezing |  | Back pain | **Gynecologic** |
| Hematologic |  | Gait/balance problems |  | Painful Menses |
|  | Swollen lymph nodes |  | Joint swelling |  | Irregular menses |
|  | Bruises easily |  | Muscle aches |  | Breast lumps/pain |
|  | Bleeds easily |  | Neck pain |  | Vaginal dryness |
|  |  |  |  |  | Pain with intercourse |