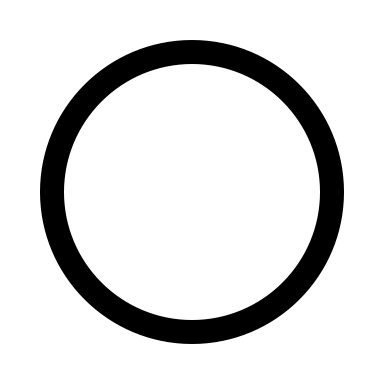
**New Patient Medical History Form**

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)

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

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***

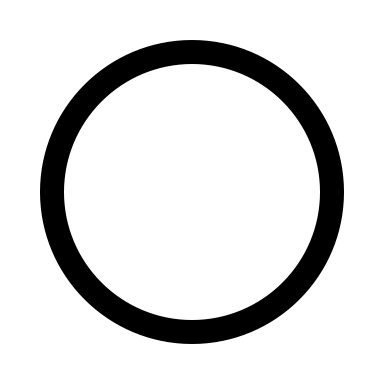
|  |  |  |  |
| --- | --- | --- | --- |
| Disease/Condition | Current | Past | Comments |
| Asthma |  |  |  |
| Cancer (*type*): |  |  |  |
| Depression/Anxiety/Bipolar/Suicidal |  |  |  |
| Diabetes (*type*): |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

***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 | |