# NEW PATIENT
# MEDICAL HISTORY FORM

1905 Clint Moore Rd, Ste 202
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(561) 757-5530

Legal Name: _____ M ☐ F ☐ Date: _____

*Preferred Name (if different than above)* : _____ Birth Date: _____

Date of Last Physical Exam: _____

Reason for today's visit: _____

## ALLERGIES ☐ NO ALLERGIES

| ALLERGY | REACTION IT CAUSES? |
|---|---|
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## MEDICATIONS *(Prescription and Over The Counter)* ☐ NO MEDICATIONS

| MEDICATIONS *(Please list ALL)* | DOSE *(Mg, pill, etc.)* | TIMES PER DAY |
|---|---|---|
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*If you need more room to list medication, please write them on a blank sheet of paper with the required information.*

## HEALTH MAINTENANCE SCREENING TEST HISTORY

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **COLONOSCOPY/SIGMOID** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **BONE DENSITY (DEXA)** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **(WOMEN) MAMMOGRAM** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **PAP SMEAR** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **(MEN) DIGITAL RECTAL EXAM** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **PSA (PROSTATE BLOOD TEST)** | Date: | Facility/Provider: | Abnormal Result? Y N |

## VACCINATION HISTORY

| | |
|---|---|
| Last Tetanus Booster or Tdap: | Last Pneumovax *(Pneumonia):* |
| Last Flu Vaccine: | Last Prevnar: |
| Last Zoster Vaccine (*Shingles):* | COVID-19: Manufacturer: Doses: |

## PERSONAL MEDICAL HISTORY

**CONDITIONS** ***Check √ conditions you currently have or have had in the past***

| | | | | |
|---|---|---|---|---|
| ☐ A-Fib | ☐ Bulimia/ Anorexia | ☐ Epilepsy | ☐ Kidney Disease | ☐ Sexually Transmitted Disease |
| ☐ AIDS | ☐ CAD / Heart Disease | ☐ GERD (reflux) | ☐ Kidney Stone | ☐ Sleep Apnea |
| ☐ Alcoholism | ☐ Cancer (list type below) | ☐ Glaucoma | ☐ Liver Disease | ☐ Stroke |
| ☐ Allergies/Seasonal | _____ | ☐ Gout | ☐ Migraine Headaches | ☐ Suicide attempt |
| ☐ Anemia | _____ | ☐ Headaches | ☐ Multiple Sclerosis | ☐ Thyroid Problem |
| ☐ Anxiety/Bipolar | _____ | ☐ Heart Disease | ☐ Osteoporosis | ☐ Tuberculosis |
| ☐ Arthritis | ☐ Dementia | ☐ Hepatitis | ☐ Pacemaker | ☐ Ulcer(s) |
| ☐ Asthma | ☐ Depression | ☐ Herpes | ☐ Pneumonia | ☐ Vaginal Infections |
| ☐ Bleeding Disorder | ☐ Diabetes (type: _____ ) | ☐ High Blood Pressure | ☐ Prostate Problem | Other: _____ |
| ☐ Blood Clot (DVT/PE) | ☐ Drug Abuse | ☐ High Cholesterol | ☐ Psychiatric Care | _____ |
| ☐ Bronchitis | ☐ Emphysema/COPD | ☐ HIV Positive | ☐ Rheumatic Fever | _____ |

## SURGERIES ☐ NO SURGURIES

| **TYPE** *(specify left/right)* | **DATE** | **LOCATION/HOSPITAL/SURGEON** |
|---|---|---|
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## OTHER HOSPITALIZATIONS

| **YEAR** | **REASON** | **HOSPITAL/LOCATION** |
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## BLOOD TRANSFUSION: NO ☐ YES ☐

**If yes, Date(s)**

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## FAMILY MEDICAL HISTORY ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

| | Mother | Father | Sister | Brother | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| Age if living, Age at death, Cause of Death | | | | | | | | | | |
| Alcohol/Drug Abuse | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Bipolar/ Suicidal | | | | | | | | | | |
| Cancer (type: _____ ) | | | | | | | | | | |
| COPD/ Emphysema | | | | | | | | | | |
| Dementia | | | | | | | | | | |
| Depression/ Anxiety | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Early Death | | | | | | | | | | |
| Heart Disease | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Migraines | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | |
| Other: _____ | | | | | | | | | | |
| Other: _____ | | | | | | | | | | |

## SOCIAL HISTORY

| | |
|---|---|
| Occupation (or prior occupation): | ☐ Retired ☐ Unemployed ☐ LOA ☐ Disabled |
| Employer: | Yrs of Education or Highest Degree: ☐ High School ☐ College ☐ Other: _____ |
| If employed, do you work the night shift? ☐ Yes ☐ No ☐ N/A | |
| Marital Status *(check one):* ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: _____ | |
| Do you have children? | If yes, how many? |
| Household (who lives in your household?) _____ | Religious Preference: _____ |

## HEALTH HABITS & PERSONAL SAFETY

| | | | |
|---|---|---|---|
| **TOBACCO USE** | Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol/Drug Use)* | | |
| ***Current:*** Packs/day _____ # of Years _____ | ***Past:*** Quit Date: _____ Pack/day_____ # of Years _____ | | |
| Other Tobacco *(check one)* ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew | | | |
| **ALCOHOL/DRUG USE** | Do you drink alcohol? Y N | ☐ Beer ☐ Wine ☐ Liquor | # of Drinks/week |
| Are you concerned about the amount you drink? | | Yes | No |
| Have you considered stopping? | | Yes | |
| Have you ever experienced blackouts? | | Yes | No |
| Are you prone to "binge" drinking? | | Yes | No |
| Do you drive after drinking? | | Yes | No |
| Do you use marijuana or recreational drugs? Y N | Have you ever used needles to inject drugs? Y N | | |
| Have you evern taken someone else's drugs? Y N | | | |
| Caffeine Intake: ☐ None ☐ Coffee ☐ Tea ☐ Cola | # of cups or cans per day? _____ | | |

| | | | |
|---|---|---|---|
| **SEXUAL ACTIVITY** | Sexually involved currently? Y N *(If no sexual history, please continue to next section, EXERCISE)* | | |
| Sexual partner(s) is/are/have been: ☐ Male ☐ Female ☐ Both | | | |
| Birth control method: ☐ None ☐ Condom ☐ Pill/Ring/Patch/Inj/IUD ☐ Vasectomy ☐ Trying for pregnancy | | | |

| | | | |
|---|---|---|---|
| **EXERCISE** | Do you exercise regularly? Y N *(If you answered no, please go to next section, 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 | Would you like advice on your diet? Y N | |
| Are you dieting? | | Yes | No |
| If yes, are you on a physician prescribed medical diet? | | Yes | No |
| # of meals you eat in an average day? _____ | | | |

| | | | |
|---|---|---|---|
| **SAFETY** | Do you live alone? Y N | Do you have frequent falls? Y N | Do you have vision/hearing loss? Y N |
| Do you use a bike/motorcycle helmet? Y N | Do you use a seatbelt while driving? ☐ Always ☐ Never ☐ Sometimes | | |
| Working Smoke detector in home? Y N | Are guns kept in your home? Y N | | |
| If yes, is household aware of gun safety? Y N | Are the guns locked up? Y N | | |
| Is violence in the home a concern for you? Y N | Have you ever been abused? ☐ Physically ☐ Mentally ☐ Sexually | | |
| Have you completed an Advance Directive for Health Care (ADHC), Living Will? ☐ Yes ☐ No | | | |
| Would you like information on the preparation of these? ☐ Yes ☐ No | | | |

| | | |
|---|---|---|
| **MENTAL HEALTH** *(indicate with √)* | | |
| Is stress a major problem for you? | Yes | No |
| Do you feel depressed? | Yes | No |
| Do you panic when stressed? | Yes | No |
| Do you have problems with eating or your appetite? | Yes | No |
| Do you cry frequently? | Yes | No |
| Have you ever seriously thought about harming yourself? | Yes | No |
| Have you ever attempted suicide? | Yes | No |
| Do you have trouble sleeping? | Yes | No |
| Have you ever been to a counselor? | Yes | No |

| **WOMEN ONLY** *(indicate with √)* | | | | |
|---|---|---|---|---|
| Age at onset of menstruation: | Date of last menstruation? | Period every days | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | | | Yes | No |
| Number of pregnancies: | Number of live births: | Pregnancy Complications: | | |
| Are you pregnant or breastfeeding? | | | Yes | No |
| Any urinary tract, bladder, or kidney infections within the last year? | | | Yes | No |
| Any blood in your urine? | | | Yes | No |
| Any problems with control of urination? | | | Yes | No |
| Any hot flashes or sweating at night? | | | Yes | No |
| Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period? | | | Yes | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | | | Yes | No |

| **MEN ONLY** *(indicate with √)* | | |
|---|---|---|
| Do you usually get up to urinate during the night? | Yes | No |
| If yes, # of times | | |
| Do you feel pain or burning with urination? | Yes | No |
| Any blood in your urine? | Yes | No |
| Do you feel burning discharge from penis? | Yes | No |
| Has the force of your urination decreased? | Yes | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | Yes | No |
| Do you have any problems emptying your bladder completely? | Yes | No |
| Any difficulty with erection or ejaculation? | Yes | No |
| Any testicle pain or swelling? | Yes | No |

## OTHER PROVIDERS/SPECIALISTS

| SPECIALIST | NAME | LAST VISIT |
|---|---|---|
| Cardiology | | |
| Gastroenterologist (GI) | | |
| OB/GYN | | |
| Neurology | | |
| Pulmonary | | |
| Other: _____ | | |
| Other: _____ | | |

## ADDITIONAL INFORMATION

| | |
|---|---|
| Have you traveled outside of the country in the last 30 days? Y N | If yes, where? |
| Have you served in the military? Y N | If yes, how long and what branch? |
| Were you deployed? Y N | If yes, where? |

**Patient Name:** _____ **DOB:** _____