NEW ADULT PATIENT MEDICAL HISTORY

MAGNIFICAT FAMILY MEDICINE LLC

Name:_____Date of Birth: _____

Age:_____ Sex: Male☐ Female☐

Today's Date: _____

Please tell us the **REASON FOR TODAY'S VISIT** or any special concerns you would like to discuss with your provider today:

_____

_____

Please list your **CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS:**

Name	Dosage (i.e., MG)	How Taken (i.e., 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (i.e., rash, nausea)

Please provide your **IMMUNIZATION HISTORY:** **Immunization Preference (circle one):** Traditional None

	Yes	No	Date		Yes	No	Date
Tetanus-Diphtheria Booster	☐	☐		Hepatitis A Vaccine	☐	☐	
Influenza Vaccine (Flu Shot)	☐	☐		Hepatitis B Vaccine	☐	☐	
Pneumococcal Vaccine	☐	☐		Human Papilloma Virus (HPV)	☐	☐	
Tuberculosis (TB) Skin Test	☐	☐		Varicella Vaccine	☐	☐	

Please provide your **PAST MEDICAL HISTORY:**

- ☐ Allergies
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (enlarged prostate)
- ☐ Blood clots
- ☐ Cancer, type_____
- ☐ CVA (stroke)
- ☐ COPD (emphysema)
- ☐ CAD (hear disease)
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder disease
- ☐ GERD (reflux)
- ☐ Hepatitis C
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ MI (heart attack)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal disease (kidneys)
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Other_____

PAST OPERATIONS: What operations have you had?

Type of Operation	When it happened	Doctor or Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide your **SOCIAL HISTORY:**

Do you Smoke? ☐Yes ☐No ☐Former
- Type of tobacco:_____
- Packs per day: _____
- Years smoked: _____
- Years quit: _____
- Have you ever tried to quit? ☐Yes ☐No

Occupation:_____
Last Grade Completed:_____
Hours a Day watching TV: _____
EXERCISE: #of days/wk: _____ #of hrs/day_____
Have you ever seen a counselor? ☐Yes ☐No
If yes, what for? _____
Marital Status: ☐M ☐S ☐D
Spiritual belief/Religion:_____

Are you currently sexually active? ☐Yes ☐No ☐Former
- Method of Family Planning? _____
- Total # of Lifetime Partners: _____

Do you drink Alcohol? ☐Yes ☐No ☐Former
- Type of alcohol: _____
- Frequency and Amount:_____
- When was your last drink? _____

Do you use Illegal drugs? ☐Yes ☐No ☐Former
- Type of drug: _____
- Frequency and Amount:_____

Do you have an eating disorder? ☐Yes ☐No ☐Former
Do you view pornography? ☐Yes ☐No ☐Former
Other Addictions? _____

FOR FEMALES ONLY:

Age at First Period: _____
Date of Last Menstrual Period: _____
Date of Last Mammogram: _____
Date of Last Pap Smear: _____
Any history of abnormal pap smears ☐Yes ☐No
If Yes, When: _____
History of contraceptives ☐Yes ☐No
If Yes, When:_____

Are periods ☐Regular ☐Irregular
☐Menopause ☐Hysterectomy
Is Flow: ☐Normal ☐Heavy ☐Light ☐Spotting
Do you have pain with period? ☐Yes ☐No
Or any of the following: ☐ Pelvic Pain
☐ Back Pain ☐ Breast Tenderness
☐ Mood Swings ☐ Headaches

Cycle Length (i.e. 28-30 days): _____
# of days Bleeding:_____
Number of Pregnancies: _____
Number of Live Children:_____
Number of Miscarriages:_____
Number of Abortions: _____

Please provide your **FAMILY HISTORY:**

FATHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? _____
Health Problems_____

MOTHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? _____
Health Problems_____

BROTHERS AND SISTERS: (each one, are they living?, Cause of death?, ages, other health problems)

_____
_____
_____

SPOUSE: ☐ Alive ☐ Deceased Age _____ Name:_____ Reason Deceased? _____
Health Problems_____

CHILDREN: (NAMES AND AGES, living or deceased, Cause of death?, ages, other health problems)

_____
_____
_____

Does anyone in your family have these health conditions? (Please check & list relation even if listed above)

_____Heart Problems (heart attacks, heart failure)
_____Breast Cancer
_____Colon Cancer
_____ Prostate Cancer
_____ Skin Cancer
_____ Diabetes
_____ Strokes
_____ Mood disorders (anxiety, depression, bipolar, etc.)

HEALTH MAINTENANCE: (Please list Date)

Last Dental Appointment: _____
Last Eye Doctor Appointment: _____
Last Cholesterol: _____
Last Blood Sugar: _____
Last Heart Scan/Stress Test/Echo:_____
Last Colonoscopy: _____

PATIENT SIGNATURE: _____ **DATE:** _____

PHYSICIAN REVIEWED: _____ **DATE:** _____