Arlington Family Healthcare

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ (LAST) _____ (FIRST) _____ (M.I.) **D.O.B.** ____/____/____

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

_____

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of _____ packs/day for _____ years. I quit in _____(year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ (LAST) _____ (FIRST) _____ (M.I.) **D.O.B.** ____/____/_____

Please check "X" the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General	Fatigue / Tired	☐Yes	☐No
	Fever / Chills	☐Yes	☐No
	Headache	☐Yes	☐No
	Weight Loss	☐Yes	☐No
	Weight Gain	☐Yes	☐No
	Other: _____		
Eyes	Difficulty Seeing	☐Yes	☐No
	Other: _____		
Head	Dry Mouth	☐Yes	☐No
Ears	Hearing Problems	☐Yes	☐No
Nose	Hoarseness	☐Yes	☐No
Throat	Lumps/Swelling in Neck	☐Yes	☐No
	Sore Throat	☐Yes	☐No
	Trouble Swallowing	☐Yes	☐No
	Other: _____		
Cardiac	Chest Pain	☐Yes	☐No
(Heart)	Irregular Heart Beat	☐Yes	☐No
	Pain with Walking	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Swelling in Feet/Ankles	☐Yes	☐No
	Other: _____		
Neuro	Dizziness	☐Yes	☐No
	Fainting	☐Yes	☐No
	Headache	☐Yes	☐No
	Memory Loss	☐Yes	☐No
	Numbness	☐Yes	☐No
	Weakness	☐Yes	☐No
	Other: _____		
Respiratory	Cough	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Use of Inhalers	☐Yes	☐No
	Wheezing	☐Yes	☐No
	Other: _____		
Gastro-	Abdominal Pain	☐Yes	☐No
Intestinal	Blood in Stool	☐Yes	☐No
	Change in Bowel Habits	☐Yes	☐No
	Constipation	☐Yes	☐No
	Heartburn	☐Yes	☐No
	Loss of Appetite	☐Yes	☐No
	Nausea	☐Yes	☐No
	Vomiting	☐Yes	☐No
	Other: _____		

Males	Blood in Urine	☐Yes	☐No
Only	Difficulty Achieving Erection	☐Yes	☐No
	Foul Odor in Urine	☐Yes	☐No
	Pain in Testicles	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
	Other: _____		
Females	Breast Discomfort	☐Yes	☐No
Only	Irregular Bleeding	☐Yes	☐No
	Last Menstrual Cycle *Date:* _____		
	Painful Intercourse	☐Yes	☐No
	Post Menopausal Bleeding	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
	Vaginal Discharge	☐Yes	☐No
Musculoskeletal			
	Back Pain	☐Yes	☐No
	Joint Pain	☐Yes	☐No
	Muscle Pain	☐Yes	☐No
	Swelling	☐Yes	☐No
	Other: _____		
Skin	Bruising	☐Yes	☐No
Hair	Hair Loss	☐Yes	☐No
Nails	Nail Problems	☐Yes	☐No
	Rash	☐Yes	☐No
	Skin Changes	☐Yes	☐No
	Other: _____		
Mental	Anxiety	☐Yes	☐No
Health	Depression	☐Yes	☐No
	Difficulty Sleeping/Concentrating	☐Yes	☐No
	History of Physical/Mental Abuse	☐Yes	☐No
	Mood Swings	☐Yes	☐No
	Stress	☐Yes	☐No
	Suicidal	☐Yes	☐No
	Other: _____		

Recent Tests/ Health Maintenance (Give month/year of last exam in right column. Check left column if date is estimated.)

- ☐ Bone Density: _____
- ☐ Colonoscopy: _____
- ☐ Diabetic Foot Exam: _____
- ☐ Eye Exam: _____
- ☐ Mammogram: _____
- ☐ Pap Smear: _____
- ☐ Physical: _____
- ☐ PSA: _____
- ☐ Tetanus Shot: _____