New Patient Medical History

Miles Family Medicine

*Please complete this entire form so that we may better care for you and your health. Just ask if you need help. Remember, **this is confidential information** and we will not share it without your direct permission.*

Full Name_____Name you would like to be called:_____

Date of birth _____

Reason for today's visit:_____

Review of Symptoms

Please circle each of the following you are currently experiencing or have experienced recently:

General:	fever; chills; weight loss; weight gain; fatigue; weakness
Respiratory:	cough; shortness of breath; wheezing;
Cardiac:	chest pain; racing heart; heart fluttering
Gastrointestinal:	nausea; vomiting; diarrhea; constipation; rectal bleeding; abdominal pain
Urinary:	painful urination; frequent urination; blood in urine
Genitals:	discharge; abnormal odor; painful sex
Skin:	rash; discoloration; wounds; hair loss; change in a mole
Neurological	loss of consciousness; double vision; dizziness; lightheadedness; headaches
Mental health	anxiety; depression; difficulty concentrating; insomnia
Musculoskeletal:	joint pain; joint swelling; stiffness; muscle aches; back pain
EENT:	eye problems; sore throat; hearing difficulties, sinus problems, runny/stuffy nose

List ALL current medicines, including over the counter and herbal supplements and birth control:

medication	dosage	frequency	medication	dosage	frequency

*Allergies to medications:*_____

Previous/Current medical problems(circle if appropriate)

Allergies	Cancer (list type)	Hepatitis	Stroke
Anemia	Cirrhosis of liver	High Blood Pressure	Thyroid disease
Angina	Diabetes	High Cholesterol	Other (please list):
Asthma	HIV/AIDS	Kidney stones	
Back pain (chronic)	Heart disease	Kidney disease	_____
Blood transfusion	Heart murmur	Migraines	
Bronchitis (chronic)	Heart failure	Seizure	_____

List Prior Hospitalizations, All Surgeries (including cosmetic) and Other Major Procedures:

Date	Hospital	Illness/Procedure	Date	Hospital	Illness/Procedure

Reproductive History

Do you have children? _____ If yes, how many? _____ List the year each child was born:_____

Females: how old were you when you started having menstrual periods?____ How many times have you been pregnant?_____

Social History and Habits:

Are you married? _____How many people live in your home (including you)?_____

Do you smoke now?_____ in the past?_____ How much each day?_____For how many years have or did you smoke?___

Do you ever drink any alcoholic beverages?_____If yes, how much and how often?_____

Do you use any other drugs?_____If yes, which ones?_____

Family Medical History:

	Current Age	If deceased:Age and Cause	Circle their medical problems
Father	_____	_____	None, Heart disease, Cancer, Asthma, Stroke, Blood Pressure, Diabetes
Mother	_____	_____	None, Heart disease, Cancer, Asthma, Stroke, Blood Pressure, Diabetes
Brother	_____	_____	None, Heart disease, Cancer, Asthma, Stroke, Blood Pressure, Diabetes
Brother	_____	_____	None, Heart disease, Cancer, Asthma, Stroke, Blood Pressure, Diabetes
Sister	_____	_____	None, Heart disease, Cancer, Asthma, Stroke, Blood Pressure, Diabetes
Sister	_____	_____	None, Heart disease, Cancer, Asthma, Stroke, Blood Pressure, Diabetes

List other medical problems that run in the family:_____

Health Maintenance/ Disease Prevention
Please list the approximate date of the last item or last test performed. If never, write "never".

	Date	List any abnormalities or concerns
General physical exam		
Cholesterol check		
Glucose or diabetes check		
Colon cancer screening		
Prostate check (men)		
Last menstrual period (females)		
Pap smear (female)		
Breast exam (female)		
Mammogram (female)		

If we are unable to reach you over the phone or email regarding appointments or lab results,
May we leave this information on an answering machine or voice mail for the phone number you gave us?
Yes___ No___

Please list the names of any family members we may also leave this information with:

_____

If I have any studies ordered by my healthcare provider (Blood work, Xrays, Mammograms, Pap smears, MRIs, etc.) I will follow up on the results of the test and make sure I find out whether they were normal or not. If I do not hear from the doctor or assistant about the results in a reasonable time, I will call the office and talk with the staff about them.

My doctor recommends routine yearly Preventive Healthcare visits, including age- and risk-appropriate examinations and testing, and I understand it is my responsibility to seek out these services regularly, whether here or at another physician office.

I have completed this New Patient History form to the best of my ability and as fully and accurately as possible. I will alert the doctor to any changes or additions at subsequent visits.

_____
Signature of Patient Date

_____
Signature of Guardian Date
(if patient is a minor)