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/pelvic exam (female)	_____	
Breast exam (female)	_____	
Mammogram (female)	_____	

Please list the names of any family members or other contacts with whom we may leave information regarding your medications, refills, test results, appointment reminders, and other similar information:

_____

I am *responsible for my own medical care and follow up*. I understand that many medical conditions require future visits for evaluation and treatment. I will keep my appointments here and with any specialists. 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 tests and make sure I find out whether they were normal or not. If I do not hear from the doctor or staff with these results in a reasonable time, I will call the office and talk with the staff about them.

My doctor strongly advises routine yearly Preventive Healthcare (or Wellness) 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. (Most health insurers cover this visit at no cost but I will check with my specific insurance plan.)

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)