identity
MEDICAL GROUP
Physicians, Hospitals and Payers working together for the Patient

Annual History/New Patient Health History Form

Please take a few minutes to fill out this form a few days before your initial visit or annual physical exam and bring the complete form with you to your appointment. Please fill it out as best as you can and if you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Please bring health records, including any lab and test results. Thank you.

Patient Name: _____ Birth Date: __/__/__ Age: ____ Date: __/__/__

Reason for today's visit: _____

Other Concerns: _____

Personal Medical History: Please indicate if you had any of the following medical problems, with dates:

Heart Disease _____ High Blood Pressure _____ High Cholesterol _____

Asthma/lung disease _____ Diabetes _____ Thyroid Problem _____

Cancer _____ Kidney Disease _____ Other _____

Women's Health #pregnancies_____ #deliveries, vaginal_____or c-section_____ #miscarriages_____ #abortions_____

Date of last menstrual period_____ Birth control method, if any_____ Hysterectomy ☐No ☐Yes

Surgical History: Please list all prior operations, with dates:

_____

_____

Family History: Please indicate which family members **(M)-mother, (F)-father, (B)-brother, (S)-sister, (A)-aunt, (U)-uncle, (MGP)-maternal grandparent, (PGP)-paternal grandparent** have/had any of the following conditions:

(Also please note if the condition resulted in death)

Diabetes _____ High Blood Pressure _____ Cancer, specify _____

Heart disease _____ Stroke _____ High Cholesterol _____

Bleeding/clotting disorder _____ Genetic disorders _____ Depression/suicide _____

Asthma/COPD _____ Other: _____

Social History: Occupation: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Tobacco Use: ☐Never ☐Former smoker: Year quit _____ ☐Current smoker: Packs per day _____ # of years _____

Alcohol Use: ☐No ☐Yes # drinks per week _____ Is alcohol use a concern to you or others? ☐No ☐Yes

Recreational/injection drugs: ☐Never ☐Past use: Type _____ ☐Current use: Type _____

Sexual Activity: ☐No ☐Yes Current sex partners are: ☐Male ☐Female ☐Both Birth control method: _____

Have ever had any sexually transmitted disease (STD)? ☐No ☐Yes Are you interested in STD screening? ☐No ☐Yes

How do you rate your diet? ☐Good ☐Fair ☐Poor Do you exercise ☐No ☐Yes: How long? (minutes) _____ How often?_____/week

Please turn over and complete back side of form. . .

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Medications: Please list ALL medications (prescription and non-prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc.) **Which is your preferred pharmacy?** _____

Medication / Dose / How often?

_____
_____
_____
_____
_____

Medication / Dose / How often?

_____
_____
_____
_____
_____

Do you have allergies or reactions to medications (include type of reaction): _____
_____

Health Maintenance and Screening: Please list dates and results if known

Mammogram	Date: _____	Abnormal? ☐No ☐Yes
Pap test	Date: _____	Abnormal? ☐No ☐Yes
Colonoscopy	Date: _____	Abnormal? ☐No ☐Yes
Stool Cards (Fecal Occult Blood)	Date: _____	Abnormal? ☐No ☐Yes
Bone Density test	Date: _____	Abnormal? ☐No ☐Yes

Immunizations: Please list most recent dates if known

Influenza (Flu) _____ Zostavax (Shingles) _____ Tetanus (Td) _____ with Pertussis (Tdap) _____

Pneumovax (Pneumonia) _____ Prevnar 13 _____ Hepatitis A _____ Hepatitis B _____

Review of systems: Please check any persistent symptoms you have had in the past few months

Constitutional
- ☐Recent fevers/chills
- ☐Unexplained weight loss/gain
- ☐Unexplained fatigue

Eyes/Ears/Nose/Throat/Mouth
- ☐Change in vision
- ☐Change in hearing

Respiratory
- ☐Cough
- ☐Shortness of breath

Cardiovascular
- ☐Chest pain
- ☐Swelling in hands or feet

Skin
- ☐Rash
- ☐New or changing mole

Gastrointestinal
- ☐Abdominal pain
- ☐Nausea/vomitting
- ☐Diarrhea
- ☐Blood in stool or dark black stools

Genitourinary
- ☐Blood in urine
- ☐Erectile dysfunction
- ☐Increased urination
- ☐Leaking urination

Endocrine
- ☐Increased thirst
- ☐Cold/heat intolerance

Neurological
- ☐Headaches
- ☐Extremity numbness
- ☐Extremity weakness
- ☐Memory loss

Psychological
- ☐Anxiety
- ☐Depression
- ☐Difficulty sleeping

Musculoskeletal
- ☐Joint pain
- ☐Recent back pain

Blood/lymphatic
- ☐Easy bruising
- ☐Easy bleeding
- ☐Unexplained lumps

Have you completed an Advanced Directive for Health Care (ADHC), Living Will, or Physician Orders for Life Sustaining Therapy (POLST)? ☐No ☐Yes - please bring a copy for your chart.