Premier Health
Premier HealthNet

Beavercreek Family Medicine
New Patient Medical History

Patient Name/Birthdate _____

Current Medications:

_____
_____
_____
_____

Current medical problems (please put a C if you have any of the following problems, Mark with a P if you have had this condition in the past)

( ) Asthma
( ) COPD
( ) Sleep apnea ( ) on CPAP
( ) Diabetes
( ) High Blood Pressure
( ) High cholesterol
( ) Coronary artery disease
( ) Abnormal Pap smear
( ) Previous heart attack
( ) Previous stroke
( ) Atrial fib
( ) Thyroid high low
( ) GERD (reflux) ( ) Ulcers
( ) Crohns ( ) Ulcerative colitis
( ) Hepatitis
( ) Prostate disorder
( ) Cancer
( ) Anemia
( ) Deep vein thrombosis
( ) Pulmonary Embolism
( ) HIV, AIDs
( ) Depression
( ) Anxiety

Other:_____
_____

Surgical history: Please check if you have had the following surgeries

( ) Appendectomy	( ) Hysterectomy ( ) Abdominal ( ) Vaginal
( ) Breast Biopsy ( ) right ( ) left	( ) Ovaries removed
( ) Mastectomy ( ) right ( ) left	( ) Tubal ligation ( ) Vasectomy
Cataract surgery ( ) right ( ) left	( ) Tonsillectomy
( ) Cholecystectomy ( ) open ( ) laparoscopic	( ) Knee Replacement ( ) right ( ) left
( ) Coronary Artery Bypass	( ) Hip Replacement ( ) right ( ) left
( ) Hernia	( ) Cesarean section

Other Surgeries:_____
_____

Allergies and reaction: _____
_____

Family History Please check if family member has the following

	None	Mom	Dad	Sister	Brother	M GM	M GF	P GF	P GM	Other
Deceased/age										
Asthma										
Alcohol/drug abuse										
Breast cancer										
Blood Clots										
Cancer										
Diabetes										
High Blood Pressure										
High Cholesterol										
Heart disease										
Stroke										
Thyroid disease										
Depression/anxiety										

Other:_____
_____

Patient Name_____

Review of systems - Excluding episodic illnesses such as colds, please check if you have been experiencing the following symptoms or check below (-) if all negative

ROS	(-)	Please check if CURRENT positive symptoms or check ALL NEGATIVE (-) column
Constitutional		☐ Unintentional weight loss ☐ Fever ☐ Chills ☐ Poor appetite ☐ Unusual fatigue
Eyes		☐ Eye pain ☐ Discharge ☐ Redness ☐ Decrease in vision ☐ Double vision
ENT		☐ Sore throat ☐ Ear pain ☐ Hearing loss ☐ Nosebleeds ☐ Ringing in ears ☐ Sinus congestion
Cardiovascular		☐ Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart Murmur ☐ Swelling in feet or ankles
Respiratory		☐ Shortness of breath ☐ New cough ☐ Chronic cough ☐ Coughing up blood ☐ coughing up sputum
Gastrointestinal		☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Difficulty swallowing
Genitourinary (male)		☐ Painful urination ☐ Slow Stream ☐ Frequent Urination ☐ Penile discharge ☐ Blood in urine ☐ Incontinence
Genitourinary (female)		Last Menstrual period date _____ ☐ Menopausal ☐ Painful urination ☐ Frequent Urination ☐ Blood in urine ☐ Incontinence ☐ Irregular periods ☐ Painful periods ☐ Vaginal discharge ☐ Pain with intercourse
Skin		☐ Rash ☐ Hives ☐ Moles changes ☐ Skin sores or ulcers
Musculoskeletal		☐ Joint redness ☐ Joint swelling ☐ Muscles aches Pain in following ☐ Shoulders ☐ Hands ☐ Hips ☐ Knees ☐ Ankles ☐ Feet
Psychiatric		☐ Anxiety ☐ Depression ☐ Suicidal thoughts ☐ Panic attacks ☐ Controlled with medication ☐ Not controlled with medication ☐ Alcohol dependence ☐ Drug dependence
Endocrine		☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst
Neurological		☐ Unusual headache ☐ Chronic unchanged headaches ☐ Numbness ☐ Weakness ☐ Lightheadedness ☐ Vertigo ☐ Fainting
Hematologic		☐ Unusual bruising ☐ Bleeding ☐ Enlarged glands/lymph nodes
Please comment on positives		

Women: How many pregnancies? _____ # C-sections _____ # Vaginal births _____
How many live births?_____ Miscarriage _____ Abortions _____ Stillborn _____
Social history
( ) Non-smoker (never smoked) ( ) Ex-smoker ( ) Current Smoker ____ Packs per day
Alcohol consumption ( ) never ( ) occasional ( ) frequent
Recreational drugs ( ) never ( ) occasional ( ) frequent Type _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: Number of living children: _____
Occupation: _____
Occupational exposures: ☐ Asbestos ☐ Chemicals _____ ☐ Other _____
Previous blood transfusion: ☐ yes ☐ no
Highest level of education: ☐ College ☐ High school ☐ G.E.D. qOther:
Do you have any difficulty with reading or special educational needs?
_____
Health Maintenance: Have you had the following:
☐ Colonoscopy date: _____ Where: _____
☐ Pap smear date: _____ Glaucoma screening date: _____
☐ TDAP date: _____ ☐ Pneumonia shot date: _____ ☐ Shingles shot _____
(This may or may not become part of your permanent medical record. Information may be either transferred to progress note or may be scanned)