TREASURE COAST Primary Care

New Patient Medical History Form

First Name: _____ Last Name: _____ Date of Birth: ____/____/_____

Reason for today's visit:

_____

_____

Allergies: ☐ PENICILLIN ☐ SULFA ☐ ASPIRIN ☐ IBUPROFEN ☐ IODINE Others:

_____

_____

Current Medications:

Name	**Dosage**	**How many do you take & how many times per day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History: (Please mark any conditions that you have had or have)

Abnormal EKG ☐	Anemia ☐	Asthma ☐	Breast Lump ☐
Cancer: _____ ☐	Coronary Artery Disease ☐	Depression ☐	Diabetes Type I or II ☐
High Cholesterol ☐	Emphysema ☐	Heart Attack ☐	Hepatitis (type: _____) ☐
High Blood Pressure ☐	Hyperthyroidism ☐	Hypothyroidism ☐	Kidney Disease or Stones ☐
Mental Illness ☐	Migraines ☐	Osteoarthritis ☐	Osteoporosis ☐
Seizures ☐	Stomach Ulcer ☐	Stroke ☐	Tuberculosis ☐

Please list any others or clarification of anything circled above:

_____

_____

_____

Surgical History:

Have you ever had surgery? ☐ YES ☐ NO

If yes, please list the surgery and the date below. If you are not sure of the date, please give approximation.

Date **Surgery**

_____

_____

_____

_____

_____

_____

_____

_____

Family History:

If any of your close family members (grandparents, parents, siblings, children, aunts, and uncles) have had any of the conditions listed below. **Please be sure to list if the member is paternal or maternal when necessary**.

Cancer (list type, if known): _____

Diabetes (list type, if known): _____

Heart Disease/High Blood Pressure: _____

Stroke: _____

Thyroid Disease: _____

Mental Health History: _____

Health Habits:

<u>Smoking</u>

Have you ever smoked? Never ☐ Former ☐ Current ☐

If yes, how many years have you smoked or did you smoke? _____ If you did quit, what year? _____

Former or current smokers, please answer the amount: _____ packs per day

Caffeine

Do you drink caffeinated beverages? YES ☐ NO ☐ Decaffeinated Only ☐

Coffee: How many on average per day _____ week _____

Tea: How many on average per day _____ week _____

Soda: How many on average per day _____ week _____

Alcohol

Do you drink alcoholic beverages? ☐ YES ☐ NO Former Alcoholic

If yes, what beverage do you typically drink? _____

How many on average per day _____ or week _____ or month _____

Exercise

Never ☐ 1 x week ☐ 2-3 x week ☐ 4-5 x weekDaily

Preferred exercise routine: _____

Substance Abuse

Do you have any history of substance abuse? ☐ YES ☐ NO

If yes, please list the substance(s): _____

Mental Health

Do you have any history of mental illness? ☐ YES ☐ NO

If yes, please list the illness(s): _____

Communicable Disease

Do you have any history of communicable diseases? ☐ YES ☐ NO

(this would include STD's, hepatitis, tuberculosis, etc…) If yes, please list the disease(s) below:

_____

Patient Signature: _____Date: _____