NEW PATIENT
MEDICAL HISTORY FORM

LoginClinics
WHY WALK-IN WHEN YOU CAN LOG-IN?

Full Name: _____ Date: _____

Birth Date: _____ Age _____

ALLERGIES o NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

Cholesterol	Date:	Facility/Provider:	Abnormal Result? Y N
Colonoscopy/Sigmoid	Date:	Facility/Provider:	Abnormal Result? Y N
Mammogram	Date:	Facility/Provider:	Abnormal Result? Y N

Pap Smear	Date:	Facility/Provider:	Abnormal Result? Y N
bone density	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	**Date**	**Location/Facility**

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY o **No Significant Family History is Known**

4 **check all that apply**	Alcohol/ Drug Abuse	Asthma	Cancer	Emphysema(COPD)	Depression/ Anxiety	Bipolar/ Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	HighBloodPressure	Kidney disease	Stroke	ThyroidDisease	Other
Mother															
Father															
Brother															
Sister															
Child															
Grandmother															
Grandfather															
Other:_____															

SOCIAL HISTORY

Occupation *(or prior occupation)*:	o Retired o Unemployed o LOA o Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: o Single o Partner	o Married o Divorced o Widowed o Other:_____
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

Tobacco Use	Smoke Cigarettes? Y N		
Current: Packs/day _____	# of Years _____	***Past:*** Quit Date: _____. Packs/day	# of Years _____
Other Tobacco *(circle)*:	Pipe Cigar Snuff Chew		
alcohol/drug Use	Do you drink alcohol? Y N	o Beer o Wine o Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

Patient Name:_____ DOB: _____

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OTHER HEALTH ISSUES continued...

sexual activity	Sexually involved currently? Y N	
Sexual partner(s) is/are/have been: o Male	o Female	
Birth control method: None Condom IUD Pill/Ring/Patch/Inj Vasectomy Abstinence		
exercise	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____	How often: _____
sleep	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? o Good o Fair o Poor	Would you like advice on your diet? Y N
safety	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Please explain:

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		

Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name:_____ DOB: _____

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REVIEW OF SYSTEMS 4 **check all that apply**

CONSTITUTION	CARDIOVASCULAR	SKIN
Activity change	Chest pain	Color change
Appetite change	Leg swelling	Pallor
Chills	Racing Heart	Rash
Sweating	**Gastrointestinal**	Wound
Fatigue	Abdominal distention	**ALLERGY/IMMUNO**
Fever	Abdominal pain	Environmental allergies
Unexpected weight change	Rectal bleeding	Food allergies
HEAD, EAR, NOSE & THROAT	Blood in stool	Immunocompromised
Congestion	Constipation	**NEUROLOGICAL**
Dental problem	Diarrhea	Dizziness
Drooling	Nausea	Facial asymmetry
Ear discharge	Rectal pain	Headaches
Ear pain	Vomiting	Light-headedness
Facial swelling	**ENDOCRINE**	Numbness
Hearing loss	Cold intolerance	Seizures
Mouth sores	Heat intolerance	Speech difficulty
Nosebleeds	Drinking a lot	Syncope
Postnasal drip	Eating a lot	Tremors
Runny Nose	Peeing a lot	Weakness
Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
Sneezing	Difficulty urinating	Swollen Lymph nodes
Sore throat	Dysuria	Bruises/bleeds easily
Ringing in ears	Urine leakage	**PSYCHIATRIC**
Trouble swallowing	Flank pain	Agitation
Voice change	Frequency	Behavior problem
EYES	Genital sore	Confusion
Eye discharge	Blood in urine	Decreased concentration
Eye itching	Penile discharge	Dysphoric mood
Eye pain	Penile pain	Hallucinations

	Eye redness		Penile swelling		Hyperactive
	Sensitive to light		Scrotal swelling		Nervous/anxious
	Visual changes		Testicular pain		Self-injury
RESPIRATORY			Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness	**MUSCULAR**			
	Choking		Joint aches		
	Cough		Back pain		
	Shortness of breath		Problems walking		
	Stridor		Joint swelling		
	Wheezing		Muscle pains		
			Neck pain		
			Neck stiffness		

Patient Name:_____ DOB: _____