

NEW PATIENT (ADULT) HEALTH HISTORY - FMC Medical Clinic - Fayette (FMC)

TODAY'S DATE: _____

Reason for Visit Today: _____

CURRENT MEDICATIONS (prescriptions AND over-the-counter)

Medication	Dose	Frequency	Who prescribed this medication?

Drug Allergies (please list your reaction to each drug): _____

Food/latex/other allergies: _____

PAST MEDICAL HISTORY: (Please check any condition(s) that you have currently or have ever had in the past.)

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Benign prostatic hypertrophy (BPH) | <input type="checkbox"/> Polio | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Positive PPD (test for TB exposure) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Recurrent sinusitis | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Colitis | <input type="checkbox"/> Testicular problems | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Irritable bowel syndrome (IBS) | <input type="checkbox"/> Fractures | <input type="checkbox"/> Acne | <input type="checkbox"/> Problems with alcohol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Eczema | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Anaphylaxis (severe allergic reaction) |
| <input type="checkbox"/> CPAP use | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> ADHD | <input type="checkbox"/> Motor vehicle accident |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Sexually transmitted infection (STD) | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing deficit |
| <input type="checkbox"/> Abdominal aortic aneurysm | <input type="checkbox"/> Hemodialysis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Dementia | <input type="checkbox"/> Vision deficit |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer (specify) _____ | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Afib/Atrial fibrillation | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Leukemia or lymphoma | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Parkinsons Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney dialysis | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Peripheral neuropathy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Peritoneal dialysis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Measles | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart valve disease | | <input type="checkbox"/> MRSA infection | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High cholesterol | | | <input type="checkbox"/> TIA | |

HOSPITALIZATIONS / SURGERIES / INJURIES:

Year	Name of illness/operation/injury



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FAMILY HISTORY:

(Please check if any of your blood relatives have had any of the following:)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatoid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dementia | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other _____ |

Relation	Current age or "D" if deceased	Health Problems/Cause of Death
Mother		
Father		

HEALTH HABITS:

	Use daily	Use weekly	Use rarely	Do Not Use	Have used in past, but not now
Alcohol					
Caffeine					
Drugs					
Tobacco					
Herbal supplements					
Other					

Exercise (type and frequency): _____

Diet preferences or restrictions (e.g., gluten-free, vegan, etc.): _____

Spiritual beliefs/preferences: _____

HEALTH MAINTENANCE:

Up to date on childhood immunizations? Yes No

Year of last tetanus shot _____ (If you don't remember and you think it has been over 10 years check here): _____

Have you received Tdap as an adult? Yes No

Year of last flu vaccine _____

Year of last prournovax (pneumonia vaccine), if applicable: _____

Have you had the shingles vaccine? Yes No

Date of last bone density scan _____

Date of last colonoscopy _____

FOR WOMEN:

Date of last mammogram _____ Have you ever had an abnormal mammogram? Yes No

Date of last breast exam _____

Date of last pap smear _____ Have you ever had an abnormal pap smear? Yes No

of pregnancies: _____ Do you desire to get pregnant? Yes No

of births: _____ Age at first period? _____ # children currently alive _____



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* A M - H I S T - F M C *

Please check all of the symptoms that you are currently experiencing or have had in the last 6 months.

CONSTITUTIONAL	<input type="checkbox"/> Appetite change <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever <input type="checkbox"/> Night sweats	<input type="checkbox"/> Weight gain _____ lbs <input type="checkbox"/> Weight loss _____ lbs
EYES	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Wear glasses or contacts <input type="checkbox"/> Double vision	<input type="checkbox"/> Eye irritation <input type="checkbox"/> Eye pain	<input type="checkbox"/> Spots in vision <input type="checkbox"/> Vision loss
EARS, NOSE, MOUTH, THROAT	<input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Facial pain <input type="checkbox"/> Runny nose	<input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Post-nasal drainage <input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Dental pain <input type="checkbox"/> Mouth lesions <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat
CARDIOVASCULAR	<input type="checkbox"/> Chest pain <input type="checkbox"/> Decreased exercise tolerance <input type="checkbox"/> Difficulty breathing with exertion	<input type="checkbox"/> Difficulty breathing when lying flat <input type="checkbox"/> Sleep on more than 1 pillow <input type="checkbox"/> Palpitations	<input type="checkbox"/> Fainting/passing out <input type="checkbox"/> Leg pain with walking <input type="checkbox"/> Leg ulcers <input type="checkbox"/> Swollen feet/ankles
RESPIRATORY	<input type="checkbox"/> Cough <input type="checkbox"/> Sputum (phlegm) production <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pain with deep breathing	<input type="checkbox"/> Wheezing <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep apnea
GASTROINTESTINAL	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating <input type="checkbox"/> Food intolerance (explain). _____	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Reflux/heartburn	<input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Black stools <input type="checkbox"/> Bloody stools
GENITOURINARY	<input type="checkbox"/> Change in urinary stream <input type="checkbox"/> Pain with urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Awakening at night to urinate	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Feel the urge to urinate <input type="checkbox"/> Penile discharge <input type="checkbox"/> Impotence/sexual dysfunction <input type="checkbox"/> Painful menstrual cramps	<input type="checkbox"/> Pain with sexual intercourse <input type="checkbox"/> Post-menopausal <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal itching <input type="checkbox"/> Frequent UTIs
MUSCULOSKELETAL	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling	<input type="checkbox"/> Limited range of motion <input type="checkbox"/> Muscle aches <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Stiffness
INTEGUMENTARY	<input type="checkbox"/> Recent change in hair or nails <input type="checkbox"/> Recent changes in oiliness or dryness of skin <input type="checkbox"/> Lesions	<input type="checkbox"/> Changes in moles <input type="checkbox"/> Pigment changes <input type="checkbox"/> Itching <input type="checkbox"/> Rash	<input type="checkbox"/> Breast masses <input type="checkbox"/> Breast skin changes <input type="checkbox"/> Nipple discharge
NEUROLOGIC	<input type="checkbox"/> Abnormal gait <input type="checkbox"/> Weakness of a particular body part (not overall weakness) <input type="checkbox"/> Headache	<input type="checkbox"/> Incoordination <input type="checkbox"/> Memory problems <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures	<input type="checkbox"/> Slurred speech <input type="checkbox"/> Tremor <input type="checkbox"/> Dizziness or vertigo
PSYCHIATRIC	<input type="checkbox"/> Anxiety <input type="checkbox"/> Decreased concentration	<input type="checkbox"/> Irritability <input type="checkbox"/> Panic attacks	<input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Sadness/tearfulness
ENDOCRINE	<input type="checkbox"/> Increased thirst <input type="checkbox"/> Increased appetite	<input type="checkbox"/> Urinating frequently and large amount	<input type="checkbox"/> Hot-natured <input type="checkbox"/> Cold-natured <input type="checkbox"/> Abnormal menstrual pattern
HEMATOLOGIC/LYMPHATIC	<input type="checkbox"/> Easy bruising <input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Recurrent infections <input type="checkbox"/> Swollen lymph nodes	
ALLERGIC/AMMUNOLOGIC	<input type="checkbox"/> Eczema	<input type="checkbox"/> Seasonal allergies	<input type="checkbox"/> Hives



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