New Patient Medical History Form

(For All Patients 18yrs and older)

Name:_____ **Date of Birth:**_____

Please list all of your current medications and associated dosage and frequency/instructions:
(Be sure to include any "over-the-counter" medications, supplements, vitamins, etc.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List all of the allergies that you have (medications, foods, environment, etc.) and associated reaction:

_____

_____

_____

Your Medical History: ***(Please circle any condition that applies to you)***

Cancer	Heart Attack	High Blood Pressure	High Cholesterol
Diabetes	Joint Pain	History of Fractures	Blood Clots
Asthma	Shortness of breath	Migraine Headaches	Depression
Skin issues	Eye Disease	Hearing Issues	

Other: _____

Surgical History: _____

_____

When was your last: Tetanus Shot/ Tdap/Adacel _____ TB Test (PPD)_____ Colonoscopy_____

Pneumonia Shot _____ Hepatitis B Vaccine _____ Physical Exam_____

Female Patients ONLY: ***(Please skip this section if the questions do not apply to you)***

Number of total pregnancies?_____ Number of Births?_____ Date of Last Mammogram:_____

Date of last menstrual period: _____ Date of last bone density scan: _____

Date of last pap smear:_____ Are you using birth control (oral, injection, IUD, etc.) currently? _____

Do you have a Health Care Proxy? No Yes

Do you smoke? No Yes: How often: _____

Do you drink alcohol? No Yes: Number of times per week: _____

<u>Your Family's Medical History</u>: ***(Circle any condition that your <u>blood relatives</u> have)***

Cancer	Heart Attack	High Blood Pressure	High Cholesterol
Diabetes	Joint Pain	History of Fractures	Blood Clots
Asthma	Shortness of breath	Migraine Headaches	Depression
Skin issues	Eye Disease	Hearing Issues	

Other: _____

_____

_____

Please list any questions or concerns that you have below:

_____

_____

_____

_____

Patient Signature: _____ Date: _____

How did you hear about FMMC? _____

FMMC Provider Initials: _____ Date: _____