

Welcome to Summit Family Practice

As a new patient, and to help us understand any health issues you may have, please fill out the information below to the best of your ability.

Patient Name: _____ DOB: _____ Today's Date: _____

PATIENT MEDICAL HISTORY

Please answer "YES" or "NO" if you have ever had any of the following. Leave blank if uncertain.

- | | | | | | |
|-----------------|--|-----------------|--|--------------------------|--|
| Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood/Plasma Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | High/Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chickenpox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Tendency | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diphtheria | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bladder Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Smallpox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | (Please List): | _____ |
| Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |
| Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Eczema | <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |
| Hemorrhoids | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infectious Mono | <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |
| | | STD | <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |

Date of last chest X-ray: _____

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

MEDICATIONS (include supplements and over the counter)

Name	Dose/Frequency	Name	Dose/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____ **Reaction:** _____

PATIENT SOCIAL HISTORY

Marital status: Single Married Separated Divorced Widowed Living w/partner

Alcohol use: Never Rarely Moderate Daily Amount/day: _____

Caffeine use: Never Rarely Moderate Daily Amount/day: _____

Use of Tobacco: Never Previously, but quit: _____ Current packs/day: _____

Use of drugs: Never Type/frequency: _____

Exercise: Rare Occasional Daily Type of exercise: _____

Special diet: No Yes If so, type: _____

Exposure to: Fumes Dust Solvents Airborne particles Noise

FAMILY MEDICAL HISTORY

Age	Diseases	If deceased, cause of death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____
Spouse _____	_____	_____
Children _____	_____	_____
_____	_____	_____
_____	_____	_____

Over Please

Review of Systems

CONSTITUTIONAL SYMPTOMS

Good general health lately Yes No
Recent weight change Yes No
Fever Yes No
Fatigue Yes No
Snoring / sleep problems Yes No

EYES

Eye disease or injury Yes No
Wear glasses or contacts Yes No
Blurred or double vision Yes No

EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing Yes No
Ear pain or drainage Yes No
Sinus problems Yes No
Nose bleeds Yes No
Mouth sores Yes No
Bleeding gums Yes No
Bad breath or bad taste Yes No
Sore throat or voice change Yes No
Swollen glands in neck Yes No

CARDIOVASCULAR

Last cholesterol screen _____
Heart trouble / attack Yes No
Heart murmur Yes No
Chest pain / angina Yes No
High blood pressure Yes No
Palpitations Yes No
Shortness of breath while walking or lying flat Yes No
Swelling of feet or ankles Yes No
Varicose veins Yes No
Cold extremities Yes No

RESPIRATORY

Coughing Yes No
Coughing up blood Yes No
Shortness of breath Yes No
Wheezing / asthma Yes No
Tobacco use or exposure Yes No

GASTROINTESTINAL

Colon cancer screen _____
Loss of appetite Yes No
Change in bowel movements Yes No
Nausea or vomiting Yes No
Frequent diarrhea Yes No
Painful bowel movements Yes No
Constipation Yes No
Abdominal pain Yes No

Rectal bleeding or blood in stool Yes No

Heartburn Yes No

GENITOURINARY

Frequent urination Yes No
Burning or painful urination Yes No
Blood in urine Yes No
Change in urinary stream Yes No
Incontinence or dribbling Yes No
Kidney stones Yes No
Sexual difficulty Yes No
Male: last PSA _____
Male: testicle pain Yes No
Female: painful periods Yes No
Female: irregular periods Yes No
Female: vaginal discharge Yes No
Female: # of pregnancies _____
Female: # of miscarriages _____
Female: last menstr. Period _____
Female: last Pap smear _____
Female: last mammogram _____

MUSCULOSKELETAL

Joint pain or stiffness Yes No
Joint swelling Yes No
Muscle pain or cramps Yes No
Back pain Yes No
Difficulty walking Yes No
Osteoporosis Yes No

INTEGUMENTARY (skin, breast)

Rash or itching Yes No
Change in skin color Yes No
Change in hair or nails Yes No
New or changing moles Yes No
Skin cancer Yes No
Breast pain Yes No
Breast lump Yes No
Breast discharge Yes No

NEUROLOGICAL

Frequent or recurring headaches Yes No
Light headed or dizzy Yes No
Convulsions or seizures Yes No
Numbness or tingling Yes No
Tremors Yes No
Paralysis Yes No
Head injury Yes No

PSYCHIATRIC

Memory loss or confusion Yes No
Nervousness Yes No
Depression Yes No
Insomnia Yes No

ENDOCRINE

Diabetes Yes No
Thyroid Yes No
Other glandular or hormone problem Yes No
Excessive thirst or urination Yes No
Heat or cold intolerance Yes No
Skin becoming dryer Yes No

HEMATOLOGIC/LYMPHATIC

Bleeding / bruising Yes No
Anemia Yes No
Phlebitis, DVT, PE Yes No
Past transfusion Yes No
Enlarged glands Yes No

ALLERGIC/IMMUNOLOGIC

Slow to heal after cuts Yes No
Seasonal allergies Yes No
Environmental allergies _____
Food allergies _____
Immune deficiency or HIV / AIDS Yes No

Immunizations:

Hepatitis A _____
Hepatitis B _____
Pneumococcal _____
Influenza _____
Tetanus _____

Last PPD (TB test) _____

History adverse reactions to:

Penicillin / antibiotics Yes No
Morphine, Demerol or other narcotics Yes No
Novocaine / anesthetics Yes No
Aspirin / other pain meds Yes No
Tetanus antitoxin or other serums Yes No
Iodine / other antiseptics Yes No
Other drugs / medications _____

Authorization & Release: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my health. I authorize the healthcare staff to perform the necessary services I may need. I also authorize Summit Family Practice to obtain copies of medical records from my prior physicians named here.

Prior Physicians: _____

Signature of patient (or parent if minor) _____ Date: _____

Doctor's Review: