

# 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: Type / Amount (#) / day: \_\_\_\_\_

Caffeine use: Type / 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 of 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:

\_\_\_\_\_