NEW PATIENT MEDICAL HISTORY FORM

Name _____ Date_____

Thank you for choosing Lifeway Family Physicians. We welcome the opportunity to work with you to optimize your health. Please complete this questionnaire to help us get to know you and your health care needs.

What would you like to discuss today? _____
_____
_____

List medications, vitamins and supplements with dosage and frequency each day or bring a list:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List Allergies to medications, x-ray dye, or seafood and type of reaction:

1. _____ 3. _____
2. _____ 4. _____

What year was your last: Pap _____ Mammogram _____ Chest X-ray _____ EKG _____ Stress Test _____
Colonoscopy _____ Bone Density _____ Tetanus shot _____ Pneumonia Shot _____ Eye Exam _____

List Past Hospitalizations, Surgeries and significant procedures: _____

_____ _____
_____ _____
_____ _____

Specialists you see:_____

Please mark current medical conditions with a C and past medical conditions with a P.

___ bleeding problems
___ phlebitis / blood clots
___ transfusion
___ HIV
___ cancer
___ hearing problems
___ vision problems
___ sinus problems
___ allergy / asthma
___ chronic lung disease
___ high blood pressure
___ heart condition
___ stroke
___ kidney stones
___ endometriosis
___ positive test for TB
___ stomach ulcer / reflux
___ liver disease
___ hepatitis
___ gallstones
___ thyroid disease
___ diabetes
___ cholesterol
Other: _____
___ arthritis / chronic pain
___ fibromyalgia
___ chronic fatigue
___ osteoporosis
___ migraine headaches
___ seizures
___ anxiety / depression

Marital Status: ___ single ___ married ___ separated ___ divorced (year) _____; ___widowed (year) _____
Current Occupation: _____ Highest level of education completed: _____
Personal Habits: wear seatbelt _____% of the time Exercise: _____ Hobbies: _____
Tobacco use: Yes / No cigarettes: _____ pkg/day quit (year) _____ # years smoked _____ ___ cigars ___ pipe
Alcohol use: # of drinks per week _____ type:_____ Recreational Drugs: _____
Sexual History: _____ prefer opposite sex _____ prefer same sex _____ # of sexual partners in the past 5 years

Family History: Please list any serious illnesses (i.e. diabetes, blood pressure, heart attacks, strokes, cancer, cholesterol, asthma or other inherited diseases) in parents, brothers, sisters, children or grandparents, and age at time of death.

Mother_____ Siblings _____
Father_____ Grandparents_____