COMMUNITY MEDICAL CENTER | COMMUNITY PHYSICIAN GROUP

New Patient Information Form

Name:_____ Age:_____ Date:_____

What is the reason for your visit?_____

Preferred Language: _____ Previous Primary Care Provider: _____

Specialty Providers: _____ Do you have an Advanced Directive? _____

Preferred Pharmacy: _____

Medication Allergies: _____

Medications:
List any prescribed medications including over the counter medications, vitamins, and supplements that you have been taking.

Medication Name	Dose	Frequency

Medical History:
Have you ever been diagnosed or treated for any of the following?

___ Alcoholism
___ Anemia
___ Anxiety
___ Asthma
___ Breast Lump
___ Bleeding Disorder
___ Cancer (Type_____)
___ Cataracts
___ Chemical Dependency
___ Depression
___ Neurological Condition
___Diabetes
___COPD or Emphysema
___Foot Ulcers
___Fractures
___Gallstones
___Glaucoma
___Gout
___ Heart Disease/Attack
___ Hepatitis
___ High Blood Pressure
___ Autoimmune Disease
___ Dementia
___ HIV
___ Kidney Disease
___ Kidney Stones
___ Liver Disease
___ Miscarriage(s)_____
___ Migraines
___ Multiple Sclerosis
___ Prostate Problem
___ Psychiatric Care
___ Crohn's Disease
___ High Cholesterol
___ Stomach Ulcers
___ Stroke
___ Thyroid Problems
___ Urinary Tract Infection
___ Seizures
___ Pacemaker
___Attention Deficit Disorder
___ Fibromyalgia
___Osteoporosis/Osteopenia
___ Ulcerative Colitis

Family History:

Has a blood relative ever had any of the following conditions: Diabetes, High blood Pressure, High Cholesterol, Heart Disease, Stroke, Thyroid Disease, Cancer (please specify type), Osteoporosis, or other conditions.

	Age at Onset	Condition		Age at Onset	Condition
Father	_____	_____	Mother	_____	_____
Brother	_____	_____	Grandmother	_____	_____
Sister	_____	_____	Grandfather	_____	_____
	_____	_____		_____	_____
Children	_____	_____	Other	_____	_____
	_____	_____		_____	_____

Social History:

Occupation: _____

Smoking: Never___ Previously, but quit___ (when)_____Current___ packs/day___

Chewing Tobacco: Never___ Previously, but quit___ (when)___ Current___

Use of Alcohol: Never___ Rarely___ Moderate___ Daily___

Use of Drugs: Never___ Previously, but quit___ (when)___ Current___ type/frequency_____

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___

Surgeries or Hospitalizations:

Year	Type of surgery/ Reason for hospitalization	Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preventive Medicine:

Please provide the last date and location (if applicable) of your:

***Vaccines*:**

Tetanus_____

Pneumococcal_____

HPV (Gardasil) _____

Influenza _____

Shingles_____

Preventive Medicine Continued:

Colonoscopy_____

Bone Density Scan_____

Mammogram_____

PAP Smear_____

Screening Chest CT (lung cancer) _____

Check symptoms you have currently or have had within the last year.

General
__ Chills
__ Fatigue
__Fever
__Malaise
__ Night Sweats
__Weight Gain
__ Weight Loss
__ Other:_____

HEENT
__ Ear Drainage
__Ear Pain
__Eye Discharge
__Eye Pain
__Hearing Loss
__Nasal Drainage
__Sinus Pressure
__Sore Throat
__Visual Changes
__Other:_____

Respiratory
__ Chronic Cough
__ Cough
__ Known TB exposure
__Shortness of Breath
__ Wheezing
__ Other:_____

Cardiovascular
__Chest Pain
__Claudication (Lower extremity cramping with exercise)
__Swelling
__Palpitations (Heart Pounding)
_Other:_____

Gastrointestinal
__Abdominal Pain
__Blood in stools
__Change in stools
__Constipation
__Diarrhea
__Heartburn
__Loss of Appetite
__Nausea
__Vomiting
__Other:_____

Genitourinary
__ Painful Urination
__Blood in Urine
__Large volumes of urine
__ Urinary Frequency
__ Urinary incontinence
__ Urinary retention
__Other:_____

Reproductive
Women Only:
__Abnormal Pap
__ Painful Periods
__ Painful Intercourse
__ Hot Flashes
__Irregular Periods
__Vaginal Discharge
__Other:_____

Men Only:
__Erection Difficulties
__Penile Discharge
__Sexual Dysfunction
__Other:_____

N**eurological**
__ Dizziness
__Arm/Leg Numbness
__Arm/Leg Weakness
__Walking Disturbance
__ Headache
__Memory Loss
__Seizures
__Tremors
__Other:_____

Psychiatric
__ Anxiety
__ Depression
__Insomnia
__Other:_____

Integumentary
__Brittle hair
__Brittle Nails
__Hair Loss
__Abnormal Hair Growth
__Hives
__Itching
__Mole Changes
__Rash
__Skin Lesion
__Other:_____

Women Only:
__Breast Discharge
__Breast Lump

Metabolic/Endocrine
__ Cold intolerance
__ Heat intolerance
__ Abnormally Excessive Thirst
__ Abnormally Excessive Hunger
__Other:_____

Musculoskeletal
__ Back Pain
__Joint Pain
__Joint Swelling
__Muscle Weakness
__Neck Pain
__Other:_____

Hematologic/Lymphatic
__Easy Bleeding
__Easy Bruising
__Swollen Lymph Nodes
__Other:_____

Immunologic
__ Contact Allergy
__Environmental Allergies
__Food Allergies
__Seasonal Allergies
__Other:_____