Universal Primary Care New Patient Medical History Form

Name:_____**Date of Birth:**_____**Today's Date**: _____

Reason you are here:_____

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

☐ Anemia	☐ Crohn's Disease	☐ HIV/ AIDS
☐ Arthritis	☐ Depression	☐ Hypertension
☐ Asthma	☐ Diabetes	☐ Kidney Disease
☐ Cancer	☐ Emphysema	☐ Myocardial Infarction
☐ COPD	☐ Endocrine Problems	☐ Peptic Ulcer Disease
☐ Disease	☐ GERD	☐ Seizures
☐ Clotting Disorder	☐ Glaucoma	☐ Stroke
☐ Congestive Heart Failure	☐ Hepatitis	☐ Ulcerative Colitis

Personal Surgical History: Have you ever had any of the following surgeries? (Check if yes)

☐ Adrenal Gland Surgery	☐ Colon Surgery	☐ Kidney Surgery
☐ Appendectomy	☐ Coronary Artery Bypass Graft	☐ Neck Surgery
☐ Bariatric Surgery	☐ Esophagus Surgery	☐ Prostate Surgery
☐ Bladder Surgery	☐ Gastric Bypass Surgery	☐ Small Intestine Surgery
☐ Breast Surgery	☐ Hemorrhoid Surgery	☐ Spine Surgery
☐ Cesarean Section	☐ Hernia Repair	☐ Stomach Surgery
☐ Cholecystectomy	☐ Hysterectomy	☐ Thyroid Surgery

List names and dates of surgeries: _____

_____

_____

Medications: _____

_____

_____

_____

Allergies: _____

_____

Family History: Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

☐ Cancer/Polyps_____	☐ Anemia_____	☐ High Blood Pressure_____
Colon, Rectum, Anal, Stomach, Breast,	☐ Diabetes_____	☐ Anesthesia Reaction _____
Prostate, Uterus, Ovaries, Thyroid, Lung,	☐ Blood Clots_____	☐ Bleeding Problems_____
Blood, Lymphoma	☐ Heart Disease _____	☐ Hepatitis_____
Other _____	☐ Stroke_____	☐ Other_____

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Social History:

Alcohol use - ☐ Never ☐ Occasionally ☐ Daily Type_____

Tobacco use - ☐ Never ☐ Previously, but quit ☐ Packs Per Day_____for_____years

Drugs use - ☐ Never ☐ Occasionally ☐ Daily Type_____

What is your occupation?_____

Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Widowed, ☐ Separated

Name of spouse or significant other _____

Children: Number of Children_____Number of grandchildren_____

Women: Number of pregnancies_____, Number of deliveries_____- Vaginal_____, C-sections_____,

Miscarriages_____, VIPs (abortions) _____